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FINAL DRAFT

Management Review of AIDSCAP Project

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AIDSCAP Management Review
Executive Summary

Technical Considerations

Although this Program got off to a slow start - it now is about one year behind schedule - a group of well-designed and promising sub-projects now are getting off the ground. The Program also is managing a series of older projects started under predecessor programs - AIDSTECH and AIDSCOM.

At the time this review is written, AIDSCAP had projects in 17 priority countries and 27 associate countries in Asia, Africa and Latin America and the Caribbean. The Team responsible for this Review visited projects and AIDSCAP offices in a total of five countries in all three of those regions.

The AIDSCAP Program, which is run under a contract with Family Health International (FHI), is designed around three primary strategies and three supporting strategies. The primary strategies are Behavior Change Communication (BCC), condom programming and the reduction of sexually transmitted diseases (STD's). The three supporting elements are behavioral research, policy development and evaluation. Programs in priority countries conduct activities under all six rubrics. In associate countries some mix of these elements - but usually less than all six - are tailored to the specific needs of the country.

The six strategies set out above may be called *proximal* strategies; they aim at reducing vulnerability to HIV/AIDS with a direct focus on individuals. Largely absent from AIDSCAP's mission and scope of work are *contextual* interventions aimed at inducing *societal* changes in the population targeted for proximal intervention so as to reduce both individual and collective vulnerability. AIDSCAP has recognized the need to shift somewhat in the latter direction. The Team supports such a move.

The objectives of the BCC strategy are to delay the onset of sexual activity among young people, decrease numbers of sexual partners, increase appropriate STD treatment-seeking behavior and increase condom use and demand. The Team found these activities to be carefully designed based on prior needs assessments and methodically implemented including pilot field testing prior to widespread use. A constraint found here was the frequent unavailability of either condoms or STD treatment drugs or both (neither are provided under the project) so that some of the project activities undertaken were, in effect, motivating people to seek goods or services not available to them. This, of course, makes it harder to induce these audiences to seek this kind of help when it does become available.

By the end of 1994 AIDSCAP had assessed the status and trends of STD's and developed prevention and control strategies in 22 countries. AIDSCAP favors the "syndrome-based" approach at the "point of first encounter". In some countries the medical profession resists this approach, preferring laboratory support which, however, is not always available to STD patients or those they prefer to approach for treatment. Several recommendations made by the Team are aimed at reducing this resistance over time. AIDSCAP has shown commendable efforts in creating or strengthening STD diagnosis and treatment centers.

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Under its scope of work, AIDSCAP does not ensure the supply of condoms; it must rely on other sources of procurement. By the time of the Team's review, AIDSCAP had completed condom programming in 17 countries and embarked on social marketing schemes for condoms in seven countries. As of September 1994, AIDSCAP reported it was supporting more than 15,000 active outlets for condom distribution. Overall, however, sustainable access to condoms at an affordable price or free of cost remains a serious challenged to AIDSCAP's work. For example, some reluctance was noted on the part of USAID Family Planning programs to expand their condom distribution to take into account the needs generated by the AIDSCAP program. In part, at least, this reluctance appears to arise from fear that identification of condoms with AIDS and STD's might create resistance to their use for family planning purposes.

To date four thematic research grants and two commissioned research grants have been awarded. AIDSCAP also completed two research projects that had been begun under the AIDSTECH program and initiated a series of narrower studies. Approval of research grants involves a lengthy process of peer group review. While the research and thematic grants that have been approved should be of value, the Team recommends that AIDSCAP should focus future work in this area on time-limited projects with narrow objectives, rapid turn-around time and of direct applicability to the improvement of program delivery.

The Team also noted that several members of the Technical Working Group which peer-reviews research proposals for this project were also principal investigators or co-investigators of AIDSCAP funded research (although none had participated in the award of grants to their own projects). The Team recommends that this practice be discontinued.

Both program monitoring and process evaluation have provided clear indications of expanded activities with increasing outreach and coverage in most of the projects visited. The Team believes that at this time a better definition of target populations, both in qualitative and quantitative terms, is desirable. The Team also recommends increased efforts in the refinement of evaluation indicators and processes. AIDSCAP also should define or re-define its sub-projects specifically in terms of primary objective, i.e. research, demonstration or service, so as to be better able to assess success or failure.

In the area of policy development AIDSCAP is doing effective work in a number of the countries visited having produced a number of studies demonstrating clearly to policy makers the need for a strong national policy on AIDS. More work needs to be done in some countries, however, to convince governments to accord a hierarchical position to AIDS organizations commensurate with the high priority placed on the problem itself.

The Team also recommends that USAID incorporate, in its pre-project appraisal documents for all of its own projects, impact assessments showing their likely impact, positive or negative, on HIV/AIDS in country *and* the possible impact of AIDS on the attainment of project objectives.

The Team found, in all countries visited, that AIDSCAP country programs presented a satisfactory degree of relevance to AIDSCAP's scope of work. In all such countries AIDSCAP had undertaken activities under every priority strategy and a varying mix of support strategies. The third support strategy - policy development - was unevenly present in the countries visited.

The widespread and effective provision of technical assistance to associate countries and to USAID Missions carrying out their own AIDS programs is exerting heavy pressure on AIDSCAP's Regional Offices, particularly in Africa and Asia. The Team believes that AIDSCAP

should now consolidate its work in priority countries and in those associate countries where commitments have been made. With some exceptions, it should refrain from engaging in new country programs or projects.

Management and Operational Considerations

The AIDSCAP Program is about one year behind schedule. The main reason for this is the decision by USAID, about two-and-one-half years into program execution, to change the agreement with FHI from a cooperative agreement to a contract. Implementing that change delayed the start of many sub-projects and brought others to a halt for long periods just when they should have been getting into implementation. This switch still is causing confusion in the field.

In Africa delays also were caused by the long delay incident to finding a USAID Mission willing to have the AIDSCAP Regional Office in country and, after Kenya finally was identified, serious and probably avoidable logistics problems in setting up there. Additionally, in the Team's view, the original time-table for this program probably was too ambitious for an undertaking of this scope and magnitude.

One result of these delays was that the Team saw few sub-projects initiated under the AIDSCAP program that were far enough advanced to permit of evaluation. Accordingly, the Team recommends that another evaluation of AIDSCAP's sub-projects be undertaken about the end of FY 1995 and that no decision on a continuation of AIDSCAP, in its present form, be taken before then.

The Team also recommends that the FHI/AIDSCAP contract be extended for one year beyond its present termination date. This will not only provide more time for present sub-projects to reach fruition but will also allow time to fully involve USAID Missions in the design of any follow-on activity. (See below).

According to USAID/Mission personnel interviewed in the course of this review, Mission personnel were not involved in the design of the AIDSCAP program. (They have been consulted on AIDSCAP activities in their countries, of course.) In the Team's view this was a mistake. In Africa this fact contributed directly to the suspicion of the AIDSCAP program by Mission personnel that still impedes full cooperation in some countries. In LAC, while relations are good between the field based people of both organizations, in one of the USAID Missions visited some personnel made it clear that they wanted as little to do as possible with AIDSCAP Washington.

Also lying behind some of these feelings, in the Team's opinion, is the fact that AIDSCAP is a highly centralized organization dealing, in USAID, with a highly decentralized organization. The different needs of the two organizations at the field level do not always appear to coincide.

AIDSCAP *is* a highly centralized organization. For example, of its 101 technical employees, 40 are stationed in Washington while 61 are in the field. That staffing pattern is symptomatic of a management style - forced in part by USAID's contract and the design of the program - which concentrates nearly all management decisions in its headquarters office. This includes approval of sub-projects and of sub-project agreement. Time involved in getting these and other approvals from AIDSCAP headquarters (and also from USAID/W) can - and often does - result in serious delays in program implementation. The Team recommends that AIDSCAP now should take serious and far-reaching steps to decentralize. At the same time, the Team notes that this may require a contract amendment.

AIDSCAP's staff is well-trained and dedicated. No instances of overstaffing were noted. Indeed, there may be some understaffing in the field. The Team saw some instances of stress probably due to a combination of work-load and dedication. Decentralization would involve moving some people from Washington to the field and might require some additional positions. (Some additional staff may be needed in some of the Finance Offices in the field. See the section on Finance, below.) Turnover rate does not seem to be excessive though it may have had some impact on delaying operations in Africa.

While many USAID Missions have at least sporadic contact with international organizations (including bi-lateral donors) working on AIDS in their countries, and while AIDSCAP has frequent contact with the international AIDS bureaucracy, more needs to be done in the area of international coordination. Given the magnitude of the problem and the paucity of resources available to meet it, every effort should be made to mobilize international resources and to ensure that they are brought to bear fully and efficiently. The highest levels of USAID may have to become involved.

Financial Management Aspects

The Team noted a number of areas in which AIDSCAP's financial management could be strengthened and streamlined. Underlying most of these is the fact that AIDSCAP's financial management systems are designed almost entirely to provide monitoring information to USAID and hardly at all to provide AIDSCAP managers with the information they need for more informed day-to-day operational decisions.

In general, control systems are in place to assure proper expenditure of project funds and to provide a paper trail for auditing purposes. In some field offices and in some Implementing Agencies, however, lack of staff or inadequately trained staff or (in the case of some IA's, volunteer workers) could cause problems. Regular external audits are carried out by the accounting firm of Ernst and Young under contract to FHI.

In the Team's opinion budgeting procedures need to be tightened. The present review found a number of cases of overbudgeted projects and some examples of underbudgeting (one in which a $400+ thousand project overspent its budget by well over $200 thousand. It appears to the Team that there may be more money left in this project than the current figures show.

The Team found that cash advances to the field and to IA's cover a 90 day estimate of needs. Under USAID regulations, unless a waiver is issued, advances should be limited to 30 days.

The practice in some countries of allowing IA's to maintain interest-paying bank accounts and to use some of the interest for project purposes - while designed to protect against inflation - also requires a USAID waiver.

The Team believes that the Finance Departments of AIDSCAP should consider themselves as not just support functions but as fully integrated "members of the team". To this end they should draw up goals and objectives and annual work plans. Part of such plans should consist of providing more regular and in-depth training in the financial management area to Country Offices, Resident Advisors and, most importantly, to Implementing Agencies. To the greatest extent possible this training and TA should be carried out from Regional Offices. This work would greatly enhance the sustainability of local IA's.

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I. Background

A. First USAID Response to the HIV-AIDS Epidemic

Encouraged and assisted by USAID/W, WHO assumed worldwide leadership in promoting interventions for AIDS prevention and control establishing the Special Global Programme for AIDS (WHO/GPA) in November 1986. Beginning in FY86, USAID/W provided direct funding for GPA on an annual basis.

In April 1987, the USAID Administrator approved the first Agency AIDS Policy Guidance which called for continued assistance to WHO in its lead role and included a new emphasis on bilateral efforts in areas where USAID seemed to have a comparative advantage over other donors—operations research, economic analysis, social marketing and communications, training, information dissemination, technical and program support, use of the private sector and health-care financing.

The first USAID bilateral project to be developed was called AIDSCOM. This $19 million project, which provided technical support for public health communications efforts in AIDS prevention and control, was transferred to and folded in under the next project to be developed—an umbrella project titled AIDS Technical Support Project (ATSP), which was authorized in May 1987, for a grand total of $69 million.

B. AIDS Technical Support Project (ATSP) No. 936-5972

It was anticipated that the AIDS problem would remain a significant public health issue well into the next century, and that assistance provided by USAID should foster the development of an institutional base that would be capable of mobilizing broad support and be committed to fighting the spread of AIDS in the long term. USAID already had an established track record in institutional development in the fields of contraceptive research, diarrheal disease control, agriculture and social marketing. The new ATSP umbrella project was designed to provide USAID with a flexible and rapid response capability to meet anticipated country needs for assistance in a broad range of areas related to AIDS prevention and control.

ATSP provided support for a variety of activities including communications, basic operations support, provision of commodities, epidemiological surveillance, provision of laboratory equipment, training, operations research, information exchange and technical support. The PP called for the development of a "specialized institution" that would bring together a centralized critical mass of expertise in a number of disciplines essential for addressing the complexity of scientific, social and policy issues involved in AIDS control. New and improved methods for the control and prevention of AIDS would be tested and disseminated in a variety of ways. Rather then develop new major bilateral projects, ATSP was to utilize the existing infrastructure of field activities in health, nutrition and family planning programs.

The original design of ATSP identified two objectives: to control and limit the spread of HIV in Africa and the Caribbean, where it was already established; and, to limit the introduction of HIV in other countries at risk in Asia and Latin America.

The ATSP included four components: 1) the previously authorized AIDS Public Health Communications Project (AIDSCOM) (described in a separate PP and not included in the ATSP PP), separately contracted for $19 million over an eight year period; 2) a five-year, $28 million agreement with a "Cooperating Agency" (CA) to provide broad support for AIDS prevention and control (AIDSTECH); 3) $7 million was set aside to support efforts of other CAs and PVOs (International Red Cross, CDC); and, 4) a $15 million component was authorized to support AIDS prevention and control efforts initiated by Regional Bureaus and missions to be financed through buy-ins and/or OYB transfers of bureau or mission funds.

Management of the communications project was assigned to the Office of Education, while management of the rest of the umbrella project was assigned to the Office of Health. The management of both projects was to include substantial input from the Offices of Population, Health and Education.

In addition to the $19 million authorized for the AIDSCOM Project, the ATSP PP authorized $50 million over five years for the other three programs with two-thirds of the primary agreement to be supported by central funds and one-third by buy-ins. A country was not expected to provide buy-in funds, however, unless its program costs exceeded a "moderate upper limit."

C. Mid-term Evaluation of AIDSCOM and AIDSTECH

In March 1989, a Program Management Assessment of ATSP was conducted and in September and October 1989, an interim evaluation of the two major components—AIDSCOM and AIDSTECH—was carried out.

While much work had been accomplished in the first two years of the projects, several problems were identified. Some related to the frustration of working with HIV-AIDS prevention in general, such as trying to reduce sexually transmitted HIV in countries where sexual behavior is never openly discussed; or, experiencing a lack of full support from family planning professionals who feared promotion of condoms to high risk HIV clients would ruin the reputation of the condom as a legitimate family planning method.

Other tensions that were identified related to perceived overlaps in the range of activities being carried out by the two implementing organizations, particularly in the area of behavioral research and investigation of factors that influence sexual transmission. Some USAID missions reported that having two projects and implementing agencies—one a contractor and one a CA—was confusing. In the worst cases in a couple of countries serious turf battles occurred. Other USAIDs were able to avoid a competitive situation by inviting only one organization to work in the country.

Findings and recommendations from these evaluation exercises were used in the design of an amendment to the ATSP that was signed in April 1991. Some recommendations were easily incorporated. For example, the use of two implementing organizations was reduced to one in the AIDSCAP Project (ATSP Amendment) design. The project management responsibilities in the Office of Education were eliminated under the ATSP Amendment.

Other conclusions were specifically included in the ATSP Amendment, but continue to be issues because they were not fully implemented under AIDSCAP. Included in this list is the need to focus on applied behavioral research related to changing sexual behaviors, to conduct evaluation research to assess impact of interventions, and to document and share the lessons learned.

Other findings related to implementation problems do not seem to have been addressed. The 1989 evaluators noted, "Initiation of AIDSTECH activities have experienced delays in all three countries visited, caused by the length of time required for developing projects, and for approving sub-agreements....Approval requires input from USAID central and mission levels, the host country agencies, and FHI." The evaluators noted that field management was problematic for AIDSTECH because of the multiplicity of projects, transfer of funds and lengthy sub-agreement process. The design of complex country programs with multiple sub-agreements has not changed under AIDSCAP.

Also of note in the Program Management Assessment is the observation that despite efforts to keep the number of activities manageable, 56 of 70 USAID missions worldwide were involved in HIV-AIDS prevention and control activities. These missions included 35 in countries of Africa (AFR), 13 in Latin America and the Caribbean (LAC) and 8 in Asia and the Near East (ANE). The evaluation urged USAID/W to narrow the scope of AIDS prevention and control activities and to rank order participating countries according to high, medium and low priority. The evaluation document included discussion about mission buy-ins and the fact that in a decentralized agency like USAID, the HIV prevention program might end up being mission-driven. USAID/W was urged to avoid such "program scatteration" by clearly stating the criteria for USAID mission involvement, by ranking USAID countries by priority, and by being tenacious in turning down requests that did not meet the criteria.

The Management Assessment also pointed out that a source of tension had been the working relationship between the geographic bureaus and the HIV-AIDS Division. While the relationship had improved, the evaluators noted that it could be further enhanced by assisting geographic bureaus to develop a customized prevention strategy for each region that would provide guidance to its USAID missions.

D. Development of AIDSCAP Project—ATSP Amendment No. 2

In April 1991, the ATSP Amendment No. 2 was signed which increased the life of project (LOP) funding authorization from $38 million to $179 million; increased the project ceiling from $69 million to $319 million; extended the project assistance completion date (PACD) from 1995 to September 21, 1997, and redesigned the project by narrowing the focus of the AIDS prevention and control strategy.

A group called the AIDS Cluster had been formed to provide implementation guidance for the ATSP and for the project redesign. This team was led by a staffer from the Office of Population and included staff from the Offices of Population, Health and Education. Based on the lessons learned from the previous three years of ATSP implementation, this design team recommended that the project be amended to focus on four proven interventions: increasing demand for condoms; increasing access to condoms; reducing number of partners; and, treating STDs. The redesign was also to include country-specific communications strategies aimed at influencing behavior change, especially among risk groups.

Since it was felt that project resources had been spread too thinly to have had a measurable impact in the past, the new design strategy called for: concentration of resources and the development of an AIDS strategic plan in 10 to 15 priority countries, and short-term technical assistance in non-priority countries. The redesign aimed at "creating full scale, national programs in the priority countries and effective support activities in the non-priority countries." As a major objective the project was to have "a measurable impact on HIV incidence in the priority countries upon project completion."

From the original double purpose statement the project purpose was changed to: expand access to HIV prevention and control programs in developing countries. Four project outputs were identified including two new ones (no. 3 and 4): 1) Improved design, implementation and evaluation of HIV prevention and control programs; 2) Improved knowledge of sexual behavior and application of this knowledge to communications strategies for behavior change; 3) Establishment of an international PVO/NGO federation; and 4) Policy Reform.

In the Amended ATSP PP, achieving measurable impact on HIV incidence in the priority countries is an overriding concern of the project which includes specific monitoring, data collection and evaluation activities, including detailed AIDS Strategic Plans for data collection and evaluation; documenting impact of communications strategies by conducting behavioral research related to communications interventions in six priority countries; and preparation of semi-annual reports which present results of quantitative and qualitative data analyses.

The PP Amendment specifically calls for the integration of AIDS activities with other projects of the S&T (now Global) Bureau from the Health and Population Offices to avoid duplication of effort and to take advantage of infrastructures and service delivery approaches developed to date. The document noted that certain integration activities had already been initiated with the Office of Population Family Planning Logistics Management (FPLM) Project and the Contraceptive Social Marketing (SOMARC) Project for addressing condom distribution and sales issues. Other specific projects were identified by the AIDS Cluster design team to be included in future integration activities: Technologies for Child Health (HEALTHTECH), Maternal and Neonatal Health Nutrition (MOTHERCARE) and Contraceptive Procurement Projects.

ATSP managers were also instructed to integrate the project activities with mission strategies and bilateral health and family planning programs, and "attempt to provide assistance to all mission requests for help in any aspect of HIV prevention and control."

Citing lessons learned from population/family planning projects, the ATSP Amendment called for a "full scale program " which was to include an entire range of program components such as information, communication and education (IEC), counselling, commodities, training, research/evaluation, logistics, monitoring and supervision. These components were to be implemented "nationwide to provide effective services to prevent and control HIV infection." The project was to establish full-scale programs including all of these components in the priority countries. This full court press strategy reflected USAID experience and lessons learned in family planning programs over the years. The lesson quoted was "that multidimensional programs are the most effective and, to have impact, a family planning program must do many things well."

The amended project design called for an implementing agency that included a core staff of 36 at headquarters, a total of 48 in three regional offices (16 persons each), and a Resident Advisor in each of the 10 to 15 priority countries. Over the LOP it was estimated that 262 sub-projects averaging $200,000 per project would be developed and implemented in the priority countries. Two sub-projects were to be established during the first year in each priority country with new sub-projects implemented incrementally to a level of five sub-projects in all of the 15 priority countries. It was estimated that eight sub-projects per year would be carried out in non-priority countries. Missions were to provide 90 percent of project costs for these sub-projects.

II. Technical Assessment

Introduction

In its second decade, the HIV epidemic continues to grow relentlessly, affecting new countries, new communities, with an increasing impact on the developing world.

As of 1 January 1994, the Harvard-based Global AIDS Policy Coalition estimated that 22.2 million people worldwide had been infected with HIV since the beginning of the pandemic. Of these, 20 million were adults (11.3 million men and 8.7 million women) and 2.2 million were children. The largest numbers of HIV-infected people were in sub-Saharan Africa (15.5 million; 70 percent of global total) and Southeast Asia (3 million; 14 percent). The number of HIV-infected people in Southeast Asia already exceeded the total of infected people in the entire industrialized world. Thus, the large majority of HIV infections (20.2 million; 91 percent) had occurred in the developing world. Worldwide, an estimated 16.2 million people were living with HIV or AIDS on 1 January 1994. Globally, during 1993, 1.4 million women were newly infected, representing 40 percent of all new adult infections in that year. In sub-Saharan Africa, where HIV has been predominantly transmitted heterosexually, more women than men had acquired HIV infection: the estimated ratio in 1993 was 1.1 infected women for every infected man.

Globally, during 1993, over 350,000 children were born with HIV infection, of whom 86 percent were in sub-Saharan Africa, 10 percent in Southeast Asia, 2 percent in Latin America and 1 percent in the Caribbean.

During 1993, an estimated 1.4 million people newly developed AIDS, including 1.1 million adults and 290,000 children. Eighty-two percent of these new AIDS cases occurred in sub-Saharan Africa. In that year, for the first time, Southeast Asia had more cases of AIDS than in North America and almost twice as many as in Western Europe.

The pandemic is taking a heavy toll on young, economically productive adults and on their children. Its impact on social, health and economic development in the developing world is particularly severe.

1. Contribution of USAID and AIDSCAP to the Global Response to the HIV/AIDS Pandemic

USAID's involvement in the response to the HIV epidemic began in 1985 through the support by USAID Missions to country-based projects in Africa. In 1987, Bilateral projects were developed under two initiatives: AIDSTECH and AIDSCOM. Concurrently, strong financial support, to the Global Program on AIDS of WHO (WHO-GPA), increasing from US$6.64 million in 1987 (22% of the WHO-GPA total budget of US$ 30,26 million in that year) to US$34.04 million (46% of the WHO-GPA budget of US$73.19 million in 1993). In the late 1980s, the bulk of multilateral, multi-bi and bilateral funding of AIDS programs in developing countries was channeled through National AIDS Programs (NAPs). Such programs, in almost

all cases managed by Ministries of Health, have been created in all developing countries as the main directing and coordinating mechanism at country level.

However, as the HIV epidemic continued to spread with increasing force and complexity, HIV/AIDS programs managed by Ministries of Health lacked the resources, flexibility and structures needed to reach communities and individuals who, often marginalized and stigmatized, where at the highest risk of acquiring HIV infection. Insufficient decentralization of government programs and capacity to cooperate with NGOs/PVOs and the private sector constrained the progress of HIV/AIDS prevention and care efforts in many countries. Furthermore, because of their strong focus on health structures, NAPs were not well prepared to consider social, economic and political factors that influenced individual and collective vulnerability to HIV/AIDS. The relatively low rank occupied by Ministries of Health in government structures was—and remains—a severe limitation to their capacity to place HIV/AIDS at the required level of priority in national social end economic development. National frameworks were becoming too narrow to address HIV/AIDS from the perspective of mounting social, cultural and economic factors—such as migration and international sex trade—that could only be dealt with from a regional or subregional (cross border) perspective.

The WHO/GPA-inspired Medium Term Plans on HIV/AIDS which provided a framework for initial response to HIV/AIDS in countries were loosing their usefulness as a broad framework for action. By the early 1990's, it had become clear that, if the HIV/AIDS prevention efforts made by government programs were necessary, they were by no means sufficient to impact on the dynamic and powerful pandemic in Africa, Asia, Latin America and the Caribbean. The enhanced participation of NGOs/PVOs and the private sector in prevention and care work was indispensable.

It is against this background that AIDSCAP was designed, drawing from the experience gained through its predecessors, AIDSCOM and AIDSTECH. Under the guidance of its Technical Working Groups, AIDSCAP designed, promoted and implemented prevention strategies which were based on selected interventions born out of worldwide experience and scientific knowledge.

Based on interviews with managers and staff of international and national groups/organizations working on HIV/AIDS, the Evaluation Team noted that, after a difficult and slow start, AIDSCAP has been able over the past two and a half years to establish itself both as a credible and leading player in the global response to the HIV epidemic. The soundness and comprehensiveness of its approaches and projects and the quality and commitment of its staff have allowed AIDSCAP to exert a positive influence on the level and quality of mobilization of other organizations which take part in the response to the HIV epidemic.

Through AIDSCAP, USAID is implementing the largest AIDS focused international program in the world. With a budget of about US$ 82 million in direct and buy-in funding in 1993, AIDSCAP ranked first among the bilateral programs on AIDS. It accounted for 62.5% of the estimated US$ 136 million made available in that year through bilateral channels by industrialized countries to AIDS programs in the developing world.

By the end of 1994, AIDSCAP was operating in 17 priority countries and had subprojects at various planning and implementation stages in 27 associate countries in Africa, Asia, Latin America and the Caribbean (ANNEX 1).

As a global concern, the prevention of HIV in **any** country requires the capacity of <u>every</u> country to develop and implement effective programs. Thus, the contribution of AIDSCAP

reaches far beyond the countries where it has ongoing activities. Through the sharing of experience and the dissemination of information, the project has the potential to enhance the global capacity to respond to the pandemic. In fact, lessons are learnt through AIDSCAP which are relevant to domestic HIV/AIDS issues in the USA. For example, Family Health International (FHI) is collaborating with community-based HIV prevention programs in Florida, New York City and on the Texas-Mexico border to help them use peer education and other innovative techniques pioneered by USAID programs in the developing world. USAID, FHI and the Kaiser Foundation are working together with many businesses and community-based organizations to apply "lessons without borders" in AIDS prevention.

2. Review of AIDSCAP Strategic Elements

AIDSCAP strategies include three primary components—behavior change communication (BCC), condom programming and reduction of sexually transmitted diseases (STDs), and three support components—behavioral research, policy development and evaluation.

The first three (primary) strategic elements are built on the concept of intervention which, in essence, establishes an operational link between identified need and response to this need through a set of actions involving information, communication and the application of a technology (STD diagnosis and treatment, use of media, availability and use of condoms, among others). The basic assumption underlying interventions is that the combination of awareness about risk taking and risk reduction opportunities, and timely access to quality services and commodities will impact on behaviors and, consequently on the spread of STDs and HIV.

The design of interventions is born out of over ten years of experience and research, some of which had been contributed by AIDSTECH and AIDSCOM in the late 1980s, under USAID funding. The interventions which form the mainstay of AIDSCAP work in countries have the merit of directing activities towards distinct and measurable outputs. These interventions could be qualified as *proximal*, as they involve in most cases one or more measures of primary prevention aimed at reducing vulnerability to the acquisition of STD/HIV infection with a direct focus on the individual. **Figure 1** shows the array of approaches applied to different target populations, the mix of which varies from project to project. In order to implement these strategies, each project went through sequential phases: design, baseline data collection, implementation (including the strengthening of capacity of implementing groups through managerial capacity building, training and provision of technical support), the production of educational guidelines and communication materials and monitoring/evaluation.

In contrast to *proximal* interventions, *contextual* interventions, which are largely absent from the AIDSCAP mission and scope of work, aim at inducing societal changes in the population targeted for primary intervention, so as to reduce concurrently individual and collective vulnerability to STD/HIV infection. A key issue raised by the dichotomy which exists in the overall project design between proximal interventions (the almost exclusive focus of AIDSCAP's work) and contextual interventions (commonly omitted from AIDSCAP project design) is the extent to which the former will achieve a positive and sustainable impact when the latter is not acted upon.

AIDSCAP has recognized that, at this stage of its development, it has become necessary to expand its work in the direction of contextual interventions: a draft report on a research project on "Reducing HIV incidence in Developing Countries with Structural and Environmental Interventions"(September 1994) reflects progress in this direction although the interventions provided as examples remain closely connected to individual risk taking

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behavior and do not address broader societal issues in which collective vulnerability is deeply rooted. For example, women's status or societal discrimination against particular segments of the population raise the question of how AIDSCAP interrelates with other groups (within or outside the realm of USAID funded programs) whose mission it is to act on these issues through development programs.

Having recognized the limitations of AIDSCAP's mandate, imposed on it by its initial design, the following review will examine the extent to which the program has succeeded in planning, implementing and evaluating proximal interventions included in AIDSCAP's scope of work.

2.1. Behavior Change Communication (BCC)

The objectives of BCC are to delay the onset of sexual activity among young people, decrease numbers of sexual partners, increase appropriate STD-treatment seeking behavior and increase condom use and demand.

In all countries visited needs assessments had been performed, in most cases using questionnaires designed to assess self-reported sexual behavior and practices, and/or through focus groups or interviews of knowledgeable informants. A variety of communication support materials (pamphlets, booklets, printed inserts, posters, radio messages, videotapes) have been designed by implementing groups and are being used in interacting with targeted population groups (working young adults, in and out of school youths, commercial sex workers, and STD clinic patients, among others).

The Team found that the development of BCC activities had been implemented methodically, with attention devoted to designing communication materials appropriately and field testing them before widespread use. In Sao Paulo, Pela Vida, a project targeted at men having sex with men produced printed material and embarked on a communication strategy in October 1993 which, after three months of use, yielded little response from the target audience, reluctant to discuss serious and fear-generating messages on STD/HIV in night clubs where they were gathering. Based on this experience, the strategy and material were redesigned early in 1994 with a deliberate humorous tone and occasional entertaining events which were far better received by the target audience, although the self-referral of MSWM to STD clinics, expected to arise from the information project, had not yet shown clear results by the time of the Team's visit. This example, however, illustrates the capacity of projects to improve their design as experience is gained and successes and shortcomings are recognized.

The variety of communication support materials is so great in most countries where AIDSCAP works that projects have been developed to inventory existing material with the aim of disseminating examples and avoiding duplication in their design and production. In Thailand, AIDSCAP is in the process of creating an Information Resource Center to be managed by one of the prominent NGOs in the country; in Brazil, a similar project has begun and a directory/inventory of communication resources has been drafted which awaits funding from government or private sources. In Senegal, AIDSCAP has revitalized the IEC component of the NAP leading to the implementation of the first public information campaign in more than two years. In Kenya, with the added advantage of being physically located in the same site as the Africa Regional Office, AIDSCAP collects and disseminates information materials and supports the establishment of a resource center for the National NGO Consortium.

If the design, implementation and built-in evaluation of communication support strategies and materials have been strong and high quality components of AIDSCAP work in countries, further improvements could be considered.

First, the educational activities observed during country visits often emphasized the risk of STD/HIV infection and possible risk reduction methods but little emphasis was placed on sexuality as a pleasurable, normal function in people's life. This remark applies particularly to the education of young people who are exposed to fear-generating messages on HIV/AIDS without having been introduced, first, to the anatomy, physiology and emotional aspects of sexuality. There is often more reluctance on the part of adults to discuss sexuality--either directly or through peer education-- than reproductive health or sexually transmitted diseases. This applies particularly to school settings. **Further attempts should be made by AIDSCAP to explore the relevancy and extent to which sexuality, cast in a positive context of mutual trust and intimacy, could be introduced or emphasized further in communication strategies.**

Secondly, sex-workers-targeted projects visited by the Team seemed to have reached a stage of development which should enable project staff to refine their strategies in at least two ways: (1) the differentiation of behaviors and determinants of such behaviors within groups of sex workers; and (2) a stronger focus on clients of sex workers. Within groups of sex workers who would appear at first glance as being at an even risk of exposure to STD/HIV and therefore require standard BCC interventions, individual risk may vary considerably depending on degree of self-esteem, the weight of economic pressure, the level of education or the capacity to integrate into peer groups. In the Brazilian cities of Rio de Janeiro, Sao Paulo and Santos, in Kingston, Jamaica or in Bangkok, Thailand, AIDSCAP has made tremendous progress in reaching out to sex workers through various NGOs and in gaining their confidence. The self-reported use of condoms has increased in all situations but beyond the analysis of average use of condoms, **AIDSCAP could now induce a further phase of data analysis and target interventions more narrowly on sex workers whose behaviors and practices do not seem to have been influenced significantly by BCC. To this end, AIDSCAP should analyze the determinants of this resistance to change and develop approaches focused on this particularly vulnerable and critical sub-population.**

Clients in many subprojects were more often considered as a shadow population who could access information and education--and be motivated to use condoms--through sex workers. Few direct interventions on sex workers clients were shown to the Team apart from BCC projects aiming broadly at "sexually active young people and adults" or professional groups (truck drivers, factory workers, sailors) who were presumed to have occasional access to sex workers. **Further efforts should be developed by AIDSCAP to target clients at sites where sex work takes place.** There are examples where such initiatives have been undertaken but a considerable disparity remains between the emphasis placed on sex workers and the more discrete effort placed on reaching their clients.

Women have received more attention by AIDSCAP only recently, as reflected by the creation in 1994 of a project on HIV/AIDS prevention and social development for women and the hiring of a manager for this project. The Team was favorably impressed by this initiative which, although late in the strategic development of AIDSCAP and still formulated in broad terms yet to be translated into country-specific activities, will bring a necessary reinforced focus on gender issues.

The referral of target populations to STD diagnosis and treatment centers (and in few projects, the encouragement to seek voluntary testing for HIV) and the promotion of condoms are integral components of BCC strategy. Efforts made to stimulate early diagnosis and treatment of STDs will be discussed in a following section of this report. The referral for HIV testing is limited by several factors: the weakness of counseling services and of follow-up of people found HIV infected; the lack of testing facilities that provide quality services and protect confidentiality; and on a more basic level, the lack of documented evidence that

voluntary testing and counseling do enhance preventive behavior. These areas have benefitted from AIDSCAP's input through the production of counseling guidelines, the provision of training and the identification of appropriate testing sites. The "Drop-in Center" in Kingston, Jamaica, offers an example of an attempt to combine education of sex workers at convenient times and sites, with voluntary HIV testing. A questionnaire was used by the attending clinical nurse to record information methodically on sex workers examined at the center, but counseling (in which the attending nurse had been trained but for which no specific check-list or guideline had been issued) was expected to emerge from the filling of the questionnaire and to accompany the disclosure of the test result to the sex workers. A check list or guide specifically used for counseling might enhance the comprehensiveness and quality of this critical activity. In Kenya and Senegal testing for HIV is still a problem. The procurement of testing kits in these countries has become irregular due to the fact that WHO, the initial provider of test kits, has lost it's financial capacity to sustain its supply. No concerted effort to pick up this crucial activity was noted on the part of the government or the donor community. AIDSCAP has therefore taken the responsibility to pay for kits in Senegal for serosurveillance and in Kenya to ensure the screening of blood in transfusion centers. Voluntary testing and counseling for HIV are not available in either country. Kenya has now been chosen by AIDSCAP as one of the two African sites to host research on Voluntary Testing and Counseling.

The shortage of STD drugs and condoms which hampered the initial start and the sustainability of several projects visited raises the issue of project implementation scheduling and of the logistic support extended by AIDSCAP's counterparts who are expected to supply these commodities. **In future agreements and subagreements, AIDSCAP should be able to purchase limited amounts of commodities (drugs, test kits, condoms) to ensure the timely and smooth start-up of its BCC activities. In these planning documents, it should also spell out preconditions to implementation that will assign responsibilities to all parties involved according to a set schedule.**

2.2 Sexually Transmitted Diseases

By the end of 1994, AIDSCAP had assessed the status and trends of STDs and developed prevention and control strategies in 22 countries. STD management guidelines had been produced in 7 countries, STD program managers from 10 countries had received training; training of physicians and pharmacists in the private and the public sector had been trained in 6 and 10 countries, respectively. STD operations research was in progress in 10 countries. The STD case management strategy favored by AIDSCAP is the syndromic (or syndrome-based) approach "at point of first encounter" according to guidelines for the management of STD cases based on patient's history, signs and symptoms. Drug prescription and counseling on safer sex practices follow the establishment of a presumed diagnosis. Where available and affordable laboratory investigations may be carried out in referral centers.

In AIDSCAP project areas, however, most of the patients coming into treatment sites with STDs have limited or no access to laboratories. The syndromic approach, promoted by WHO and by the AIDSCAP TWG seems extremely well suited to the populations which benefit from AIDSCAP's interventions. Reportedly, the application of the STD syndromic management approach was received with varying degrees of support from medical professionals in AIDSCAP project areas. In Bangkok, physicians agreed to the approach being applied by nurses but remain reluctant to treat STDs without laboratory support. In Sao Paulo, a similar reluctance was expressed by medical professionals who felt that the promotion of the approach would not guarantee quality treatment, could lead to the emergence of strain resistance to antibiotics and would allegedly undermine the efforts they had made over the

years to obtain additional public funds for the development of laboratory services. This reaction to the Syndromic Management approach is in no way specific to countries where AIDSCAP works.

There are, however, at least two types of actions that AIDSCAP could consider at a time when syndromic management strategies are introduced to new fields of operations and similar obstacles as those faced in Thailand and Brazil are likely to be encountered.

First, AIDSCAP could systematize a step-by-step approach in introducing the guidelines, ensuring that professional groups that are most likely to resist their application are involved early in the development of diagnosis and treatment norms. They should be presented with data (which AIDSCAP could gather) on the estimated incidence and prevalence of STDs in the population concerned, on the estimated access and utilization rates of STD services at different levels of sophistication and completeness and on the cost of expanding laboratory services to the extent desired by medical professionals.

Second, AIDSCAP could support or stimulate more operational studies to validate diagnosis and treatment guidelines which physicians are unlikely to accept on the sole premises that they have been found effective in a neighboring country or state. Commendable efforts were developed by AIDSCAP in creating or strengthening STD diagnosis and treatment centers: for example, 11 of 16 health centers in Bangkok received equipment and training while 78 STD care providers of 15 municipalities in the state of Sao Paulo, Brazil, received training. In Africa, the STD strategy is seriously constrained by the overall lack of technical and financial resources. Although there are more countries with national guidelines for STD management today than three years ago and more health care workers have been trained, the numbers are small compared to the needs and lack of drugs and supplies limit their ability to apply their newly acquired skills. The need for targeting interventions more towards better defined "core transmitter" groups is also recognized.

In Senegal, baseline studies were completed in all four regions chosen for interventions and two subagreements were signed, one public, one private. The acute shortage of funds in Senegal lead to the signature of a subagreement between AIDSCAP and the Government which allowed rapid disbursement of US$ 7.000. Funds to purchase drugs for STD treatment were also provided by AIDSCAP under a research grant. In Bangkok, the mobility of the population expected to attend the centers (sex workers in particular) did not lead to a sustained attendance commensurate to the level of input while the supply of drugs and condoms, ensured by the municipality, was reported as regular and sufficient. In Brazil, the delays of several months that occurred between the training of care providers and their supply of drugs and condoms by public services created a gap which hampered the smooth development of the projects and generated unfulfilled expectations and frustration on the part of health centers'staffs. Added demands placed on them to monitor the use of STD drugs through a newly introduced reporting form was with resistance. It would be useful for AIDSCAP to document such experiences, perhaps through the production of case studies which could be included in the curriculum of short courses on STD case management and prepare better care providers for situations which are likely to arise at the outset of projects in other countries.

As mentioned in the above section of this report on BCC, AIDSCAP should apply more caution to the phasing of its subprojects and review the assumptions listed in each subproject agreement. Being largely of a theoretical or technical nature, the stated assumptions place little emphasis on specific operational requirements that are assumed to be met at every step of project implementation. For example, an important assumption

should be that, prior to the training of subproject staff on STD case management, a system for the regular supply of STD drugs and condoms will have been in place and that these commodities will have become available. **AIDSCAP should schedule training or institutional strengthening activities with reinforced attention paid to preconditions that have to be met at each stage of project development, before moving on to the next.**

The need for targeting certain prevention, case management and counseling specifically towards people who contribute more than others to the transmission of STDs--the "core transmitters"—is also recognized. This targeting requires the collection and analysis of selective, additional, epidemiological and behavioral information, and the adaptation of intervention to meet the specific needs of this population.

2.3 Condoms

In accordance with its scope of work, AIDSCAP does not ensure the supply of condoms but has to rely on other sources of procurement. By the end of 1994, AIDSCAP had completed condom programming in 17 countries and embarked on social marketing schemes for condoms in 7 countries. As of September 1994, AIDSCAP reported it was supporting more than 15,000 active outlets for condom distribution through which more than 66 million condoms had been sold or distributed.

Condom sales in Ethiopia increased from 3.8 million in 1991 to a projected 14 million by the end of 1994. Between November 1992 and September 1994, PSI/DKT do Brazil, an AIDSCAP implementing group, had distributed or sold over 19.5 million condoms to targeted populations, mostly in Sao Paulo and Rio de Janeiro states, and sales were following an increasing trend in spite of major obstacles encountered--and largely overcome--in importing condoms from overseas. In these two states, condom sales were expected to increase from a mere 0.4 million in 1991 to a projected 10.5 million by the end of 1994.

In Africa, the social marketing of condoms began under the auspices of USAID-supported family planning programs. However, at least partly out of fear of creating confusion among contraceptive users as to their actual objective, these programs have been rather resistant to promptly expand their condom distribution to also respond to STD/HIV prevention needs. Insufficient attempts have been made by AIDSCAP—and, in fact, most HIV/AIDS prevention programs in the world—to learn from family planning programs and build on their experience. In Kenya, the quantities of condoms distributed through AIDSCAP remain small (less than 6,000 in 1994). In Senegal, AIDSCAP supported the renovation of a warehouse for the storing of condoms but social marketing activities have been delayed as a result of pressure by the Senegalese government to carry out this initiative through a different contractor than that initially proposed by AIDSCAP. Condom sales in Ethiopia increased from 3.8 million in 1991 to a projected 14 million by the end of 1994.

AIDSCAP had been able to induce a policy change in Brazil, leading to the waiver of tariff on imported condoms. There were, and remain, unresolved difficulties created by the application by the national regulating agency responsible for the quality control of condoms (INMETRO) of quality standards in excess of internationally recommended ones. As a result, condom donations by USAID in 1994 had suffered from delays in distribution and loss or rejection of part of the shipment. In contrast, condoms are readily available in Thailand thanks to government's subsidies to the supply of condoms to the sex industry, the presence of family planning outlets and private pharmacies.

Overall, however, sustainable access to condoms at an affordable price or free of cost remains a tremendous challenge to most AIDSCAP projects visited. While the project assumed that

procurement would be guaranteed by other, international, governmental or non-governmental agencies, stated commitments did not always materialize and AIDSCAP implementing groups suffered set-backs in the conduct of their work. Several approaches could have been applied to alleviate this difficulty. For example, an initial supply by or through AIDSCAP at the outset of their project might have been allowed, concurrently with plans for alternate procurement being set into motion.

Another approach could have been to adhere to preconditions to project implementation which would have assured the availability of sufficient supplies of condoms before starting promotional activities, although this would have, no doubt, further delayed the implementation of AIDSCAP projects in many countries. Reportedly, the condom supply situation has improved over recent years and social marketing programs are exploring innovative ways to facilitate the commercial importation of condoms where barriers still remain, as is the case in Brazil.

One of the constraints to assessing the availability and use of condoms is the uncertainty prevailing about the size of the target users population. Absolute figures of condom supplied or sold are available from AIDSCAP reports but, given that the size and the estimated demand of the beneficiary population are unquantified in most of the subprojects, it is virtually impossible to estimate what proportion of projected needs are being met. Repeat cross-sectional surveys (KAP surveys) provide some indication of self-reported condom use but the reliability of such measurement methods to evaluate trends in condom use in populations which are frequently surveyed may be questionable. This issue will be discussed in more detail in a subsequent section of this report dealing with monitoring and evaluation.

Ongoing social marketing programs for condoms supported by AIDSCAP continue to be subsidized but projected sales, for example in Brazil and Ethiopia, are expected to progress towards financial self reliance of the schemes. **The Team found that, given the rising trends in condom demand and the increasing reluctance on the part of external donors to donate condoms, the social marketing approach was providing the highest guarantee of project sustainability. It recommends that AIDSCAP, through its subcontractors, should enhance its work in this area, give wider publicity to its achievements and document current and projected cost analyses of these initiatives.**

2.4 Behavioral Research

The behavioral research component of AIDSCAP work is designed to: (1) contribute to the knowledge of behaviors associated with the transmission of STD/HIV, their contexts and processes of change and methods for modifying them; and (2) test and analyze new behavior change interventions related to sexual behavior, condom use, reduction of STDs and the acceptability and sustainability of such interventions.

Since its inception in 1992 AIDSCAP completed two research projects that had been initiated by AIDSTECH: one in Jamaica (Factors influencing sexual behavior), the other in Indonesia (Condom use and sexual practices among sex workers). AIDSCAP undertook a thematic grant project in Thailand (Sexual decision making in military and sex workers) and commissioned three studies: two in Brazil (sexual behavior and condom use in dock workers and evaluation of randomized interventions in university students) and a multi-center study on counseling and testing as an HIV prevention strategy. It also conducted ethnographic assessments of STD health seeking behavior in Senegal, Ethiopia and the Philippines.

The summary of completed and ongoing research projects overseen by the Behavioral Research Unit of AIDSCAP (BRU) figures in **Annex 3.**

Studies selected for support are funded after having undergone a multi-stage review process, including a peer-review performed by the Technical Working Group on Behavioral Research, composed of prominent scientists, social and health researchers with experience in STD/HIV/AIDS research and prevention. The initial USAID grant agreement stipulated that every research proposal of a cost at, or exceeding US$100,000 should undergo peer-review. Not only these proposals but all others as well, regardless of their cost, underwent a peer-review in which a Technical Working Group established by AIDSCAP plays a central role in reviewing, assessing and commenting on these proposals, and suggesting improvements in research design. A Program Committee, composed of staff from AIDSCAP and USAID represents the final step in the decision process applied to grant awards. A summary of BRU's peer review process and of the state of progress of each proposal considered by AIDSCAP is attached as **Annex 4**.

The Team noted that, although not participating in the decision of award of grants to their own project, several members of the Technical Working Group were also principal investigators or co-investigators of AIDSCAP funded research projects. It recommended that this practice be discontinued either by the withdrawal of grant applicants (principal and co-investigators) from the relevant TWG membership, or by the disqualification of TWG members to apply for AIDSCAP research grants.

To-date, 4 thematic research grants and 2 commissioned research grants have been awarded. As reported by AIDSCAP, it takes an average 1 to 3 months—depending on whether the proposal comes under thematic research, commissioned research or unsolicited proposals—between receipt of a full (revised) proposal and final grant approval. Research grants, however, require a long gestation time which includes submission, several revisions as needed, field visits, peer review, finalization of proposal and development of a subagreement. The time elapsed between initial submission and subagreement ranged between 3 months (a thematic grant in Thailand) and over 10 months (Commissioned research in Brazil and AIDSCAP counseling and testing efficacy studies in Kenya and Tanzania). **The complexity of generating quality thematic and commissioned research projects is such that AIDSCAP should limit its support to already approved projects and focus its work on time-limited projects with narrow objectives, rapid turn-around time and direct applicability of research findings to the improvement of program delivery.**

The impact of research projects on overall strategic development within AIDSCAP or in the countries where the projects were/are located was not clearly apparent to the Team. In Jamaica, a research project initiated by AIDSTECH began in 1991, led to the production of a final report late in 1994 for a total cost in excess of US$ 600,000. The results of this study were to be analyzed later in that year at a workshop expected to feed research findings into strategic development. In Brazil, the design of two cohort studies—one in Santos the other in Sao Paulo—was modified eleven months after the approval by AIDSCAP of the initial proposal, so as to add a much wanted intervention element to ethnographic research. Based on the review of these two projects only (within the review schedule, opportunities were not available to the team to examine more projects), the Team felt that the experience gained and the lessons learnt by implementing groups as the projects were in progress had been and continued to be at least as relevant and useful as the anticipated final results of these projects.

The reports of the BRU support this finding: an AIDSCAP BRU strategy paper updated in the fall of 1994, stresses that research to be undertaken by this unit should be rapid, theory based, relevant to programs, oriented towards the development of future strategies and creative. The same strategy paper lists research issues which include: the linkages and synergy between STD/HIV and family planning programs; approaches to community

mobilization; the development of community-based care systems for people with HIV and AIDS; and the study of structural/environmental determinants of behaviors; the development and impact of policies and strategies to reach out to women in stable relationships and the youth. All of these priorities seem highly relevant to the current state of development of AIDSCAP projects and critical to achieving a more profound understanding of how contextual issues, as they relate to gender, age, community structure and societal environment can influence people's vulnerability to HIV/AIDS and, in turn, lend themselves to preventive interventions. However, the contribution that AIDSCAP should be expected to bring to the research field in the next 2 to 3 years should be examined with much caution on a country-by-country basis. **The goal of future research supported by AIDSCAP should be to generate information through research that is essential to the improvement of ongoing interventions and to the development of new ones that can be designed and tested in the short term. Thus, given the life span of AIDSCAP and the limited resources available to this program, research of a fundamental (academic) nature, based on complex study design and requiring years of data collection and analysis should receive the least priority in financial and human resource allocation.**

The Team recommends that behavioral and social research supported by AIDSCAP be closely connected to ongoing projects and that a learning process be built within each project, as they develop, so as to feed back promptly into strategic design and lead to dissemination of experience gained--as empirically based as it may be-- and replication of projects, even before final study results are deemed of a sufficient scientific quality to qualify them for publication. Thus, given the life span of AIDSCAP and the limited resources available to this program, research of a more basic nature, based on complex study design and requiring years of data collection and analysis should receive the least priority in financial and human resource allocation.

2.5 Monitoring and Evaluation

The monitoring of AIDSCAP relies on a management information system (MIS) which calls for monthly returns of process indicator forms. Process evaluation information is derived from several sources: the analysis of monitoring data, sample surveys conducted periodically, data originating from logistic program components and periodic management reviews.

Both program monitoring and process evaluation have provided clear indications of expanded activities with increasing outreach and coverage in most projects visited.

Monthly returns are used by AIDSCAP staff to discuss project performance with the staffs of implementing groups during their regular site visits. AIDSCAP HQ produces a quarterly report which summarizes, for each country, the output of each subproject as measured by such indicators as the number of people trained or educated, the quantities of condoms and materials distributed, the number and types of special events and the use of mass media. The quarterly reports also include a brief narrative on major achievements and constraints encountered in each country during the reporting quarter.

The monitoring of the subprojects and country programs, and their process evaluation, however, are constrained by several factors. First, there is in almost all projects a limited knowledge of the size of the target population and, as a result, rates (not absolute numbers) of access, coverage or use of services are impossible to derive or even estimate. Second, where estimates of populations to be reached are provided and rates calculated, insufficient or no account is taken of the renewal of the target population due to mobility and age structure dynamics. **A better definition of target populations, both in qualitative and quantitative terms is desirable. It should be updated periodically so as to focus**

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activities specifically on new members of target populations who will require specific outreach efforts.

An interesting approach developed in Thailand is the Behavioral Sentinel surveillance scheme. This monitoring/evaluation method relies on the collection and analyses of information obtained through six-monthly surveys of rotating samples of 7 segments of the AIDSCAP target population in 6 Districts of Bangkok. The term Sentinel Surveillance (which may be defined as surveillance established at fixed sites so as to capture similar population groups over time and facilitate temporal comparison of results) may not be appropriate. Nevertheless, the scheme adds to the understanding of self-reported behavior changes in response to prevention programs conducted concurrently by several groups, including AIDSCAP-supported ones. The first round was completed in January 1993 and results were analyzed and presented to the District AIDS Committees shortly thereafter. The results of the second round of interviews, conducted six months later, were being analyzed at the time of the Team's visit. Whether such periodic cross-sectional surveys should be carried out once or twice a year is arguable. Rather than conducting too frequent surveys, efforts could now be devoted to modifying the questionnaire by blending some of the existing questions with others targeted at the collection of contextual information, in an attempt to explore societal determinants which might correlate with specific behaviors and practices.

This subproject serves as an illustration of the opportunities available to AIDSCAP to enhance its intervention-linked research efforts. The subproject seems to have now attained a level of maturity and competency and acquired enough knowledge of behavioral patterns in their surveyed population to proceed towards the identification of new (contextual) interventions. It is to be noted here that the subproject has gained such a professional credibility that its staff has been hired by other groups to conduct similar surveys in Thailand and Cambodia.

The impact evaluation element of AIDSCAP is more problematic. The main indicators used for such evaluation are the Priority Prevention Indicators (PPIs), developed jointly by WHO-GPA and AIDSCAP. These indicators, which are a mix of process, impact and intermediate indicators combining qualitative and quantitative variables, may be of some use in large population groups which have a sufficient degree of homogeneity in their age, gender and risk-taking behaviors. Several PPIs, however, do not seem relevant to smaller heterogeneous populations in which risk behavior tends to cluster according to demographic and social factors. In effect, the application of PPIs intended for large population aggregates contrasts with the attempts made by AIDSCAP to focus on population groups that are at higher-than-average risk. In some of the programs to which AIDSCAP extends its cooperation--Jamaica in particular-- there are opportunities at present to reconsider the choice of PPIs, in particular those meant to provide a measure of program impact. The national AIDS program in Jamaica has already done some preliminary work towards identifying intermediate indicators that would provide a better measure of the coverage, quality and impact of STD case management. One could, for example, record where treatment was sought by a male patient with urethritis symptoms attending an STD clinic, estimate the frequency of new episodes, but--more importantly--the time intervals between referral, diagnosis, treatment and the regression of symptoms. Declining trends in the reduction of these intervals might provide a better indication of program impact than the incidence of STDs, as it may be affected concurrently by the increased spread of infection and improving performances in referral and surveillance.

Considering the recent start of its subprojects--most of which are only completing their first year or entering their second--AIDSCAP has not been able to gain sufficient experience in impact evaluation, or benefit from lessons learnt from this practical experience in order to improve its evaluation processes. Every effort should continue to be made in order to

enhance the quality of evaluation processes within each subproject. The Team found that, at the time of its visit to countries, it was premature to try to apply existing evaluation data to the assessment of subproject or program impact.

The Team recommends that reinforced efforts be devoted to the refinement of evaluation indicators and processes. AIDSCAP should prepare itself better for the most likely situation where, at the end of its project life span, it may not be able to demonstrate the impact of its work on STD or HIV trends. Firstly, the indicators and evaluation processes presently applied are inadequate to evidence such impact within most subproject populations. Secondly, because of the multiplicity of prevention programs reaching AIDSCAP's subproject populations, it is unlikely that AIDSCAP will be able to establish a cause-effect relationship between its activities and STD or HIV trends, should they be measurable in selected subprojects.

Another noted constraint to program evaluation is the uncertainty prevailing around the nature of each subproject: i.e. is a particular project a research initiative (to be evaluated on the quality and applicability of its findings)?; is it a demonstration project (to be evaluated on its cost-efficiency/cost effectiveness and replicability)?; is it an extension of services (to be evaluated on its coverage, quality of activities and sustainability)? A number of subprojects are a mix of the above and, lacking clearly stated objectives, do not lend themselves to focused evaluation.

AIDSCAP should re-examine the objectives of its subprojects and define or re-define them specifically in research, demonstration or service terms. It should then spell out criteria of success and failure that reflect the specific objectives of each subproject and adapt monitoring and evaluation processes accordingly.

2.6 Policy Development

The objectives of AIDSCAP in the area of policy analysis and development are to increase policy makers awareness of the HIV/AIDS epidemic, to identify factors which enhance or hinder HIV/AIDS programs, and to strengthen the skills of collaborating groups and individuals in countries to influence policy development. AIDSCAP's approaches to mobilizing opinion and influencing policy leaders have included the modeling of HIV/AIDS epidemics in order to project their impact on individuals, communities and nations. Such projections have been made in Colombia, Cote d'Ivoire, the Dominican Republic, Kenya and Honduras. In Kenya, the projection of the socio-economic impact of the epidemic led to the production of a position paper to be debated in parliament with the view of elevating HIV/AIDS to the level of national priorities. The exercise also contributed to sensitizing the business community and stimulating its direct involvement in HIV prevention. The policy paper produced by AIDSCAP in Kenya called for a multisectoral response to the pandemic. It recommends, however, that the existing NAP be responsible for fostering this collaboration, but its current structure and rank in the government hierarchy is unlikely to acquire the authority to achieve this goal. Although not visited by the Team, Honduras was cited as a another country where epidemiological projections had played a key role in placing HIV/AIDS on the national agenda.

Over the last several years, several countries—Thailand and Uganda in particular-- have created HIV/AIDS policy development and management mechanisms located at the highest executive level of Government and with the participation of NGOs, PVOs and the private sector. Having learned from successes and shortcomings experienced in these attempts, AIDSCAP is in a favorable position to develop and promote similar models in other countries where the Ministry of Health still remains the central focus of HIV/AIDS policy development

and decision making. In collaboration with local USAID missions and International Agencies involved in HIV/AIDS and in socio-economic development, **AIDSCAP should develop and promote models of structural and institutional adjustments required to implement HIV/AIDS policies at the level of national priority it has been accorded.**

Exploring conditions of social mobilization through support to NGOs and activities in the workplace and exploring and modeling the future socio-economic and political impact of HIV are crucial AIDSCAP contributions. AIDSCAP, or USAID itself, should further enhance its activities in the field of macro-economic impact assessment and projection relating to HIV/AIDS. AIDSCAP's capacity to influence national policies and programs will be successful only if USAID missions in countries as well as Regional Offices in the field, Regional Bureaus and the Washington sectoral Offices of USAID consider HIV as a full-blown, cross-cutting, intersectoral concern. However AIDSCAP's capacity to influence National Policies and responses will not be successful if USAID missions in the field as well as Regional Offices, Regional Bureaus and Washington sectoral offices of AID do not consider HIV as a full-blown, cross-cutting, intersectoral concern. Nowhere, at USAID/W, regional or country level has the Evaluation Team been able to identify mechanisms, whether formal or informal, that would link HIV/AIDS activities to other social and economic development programs supported by the Agency. Even the links between HIV/AIDS and Family Planning programs at these levels were weak or nonexistent. There is a pressing need for AID to formulate a policy of integration of HIV/AIDS work with (not necessarily in) other programs. **The Team recommends that the pre-project appraisal carried out by AID before undertaking social and economic development programs should consider the potential positive or negative impact such programs may have on the spread of HIV. The potential impact that HIV/AIDS may have on social and economic development supported through USAID initiatives should also form part of this pre-project appraisal process.**

AIDSCAP is confronted with complex policy issues in countries where it works. The HIV testing of job applicants, required in Thailand and Jamaica by corporations with which AIDSCAP has projects on HIV/AIDS in the Workplace is one of these issues. The consequences of a positive HIV test have severe implications in both of these countries: loss of employment opportunities, possible breaches of confidentiality, exclusion of HIV-infected job applicants from health insurance schemes. Such policies or practices are counterproductive from an HIV prevention perspective. **While it is especially relevant for AIDSCAP to work with corporations that have HIV-related discriminatory policies or practices, in order to help induce the needed changes, it should set its criteria for disassociating itself from projects that do not conform with international guidelines on HIV/AIDS prevention and are particularly resistant to change.** For example, AIDSCAP could determine a set of objectives and a time frame within which corporations would discontinue their HIV testing requirements, in accordance with international guidelines. **AIDSCAP should also ensure that national authorities, relevant international organizations (WHO in particular), local NGOs, and labor unions are made aware of policies and practices of mandatory pre-employment HIV testing and exclusion that may persist despite AIDSCAP's collaboration with corporate executives who have imposed such actions.**

3. Relevancy and Comprehensiveness of AIDSCAP Programs

The Team found that the AIDSCAP country programs it visited presented a satisfactory degree of relevancy to AIDSCAP's Scope of Work. Every program included all major and supporting strategies. At the same time, however, AIDSCAP is viewed by national AIDS programs as rigid in its capacity to extend its work to activities that do not fall within the stated scope of work

but are relevant to local needs. In Bangkok Metropolitan, AIDSCAP was able to provide only limited input to the assessment of HIV/AIDS care needs and to the design of optional care models. In Rio de Janeiro, the State AIDS Program would have welcomed AIDSCAP's support to prevention of mother-to-child transmission of HIV. In most countries, the inability of AIDSCAP to supply condoms or STD drugs at the initial phase of project development was regretted. The relevancy and adequacy of AIDSCAP's work in relation to HIV/AIDS prevention and care needs in countries was felt by the Team to be a function of three main factors: (1) the capacity of governments, or other counterparts to fulfill their own obligations as stated in project agreements; (2) the degree of integration of AIDSCAP's work in national HIV/AIDS programs; and (3) the availability to national programs of alternate source of support.

Although constrained by its scope of work and resource allocation, AIDSCAP is becoming more involved in HIV/AIDS care. The upcoming study on Voluntary Counseling and Testing is also a significant and valuable new area of involvement for AIDSCAP. **The Team recommends that, in each priority country, AIDSCAP should initiate or participate in needs assessment studies of strategic elements that are critical to effective prevention and care and publicize its findings among governmental, non-governmental and international groups in order to stimulate their response to the most acute needs that are outside the boundaries of AIDSCAP' scope of work. The "gaps" in coverage identified by these studies should form the basis for USAID coordination efforts within the international community. (See "International Coordination" under Management, below.)**

In all countries visited, AIDSCAP had undertaken activities under every priority strategy encompassed by its scope of work, and a varying mix of support strategies. Thus, each of the geographic target areas included activities in BCC, STD prevention and care, and condom programming. Within support strategies, evaluation was part of all country programs; behavioral research projects had been completed, were ongoing, or were planned in all five countries but Senegal (although several ongoing intervention projects had, in all countries, a built-in research component). The third and last support strategy—policy development--was unevenly present in country programs. This strategy has to surmount the handicap of having to build on information generated by intervention projects, research initiatives and evaluation processes, when most of these are merely at their early implementation stage. The comprehensiveness of AIDSCAP activities is generally in line with its scope of work but there are two areas where improvements will be needed in the short term: **(1) qualitative and quantitative evaluation should ascertain that every target population has access to and benefits from support generated under the three priority strategies, regardless of whether the source of such support is AIDSCAP or other group, and the extent to which this access is available and expected benefits are drawn; and (2) further efforts should be made to translate new knowledge into policy development at the local (state), national and international levels.**

In South-east Asia, AIDSCAP has expanded its activities to "Areas of Affinity" encompassing countries that have comparable levels and features of vulnerability to the spread of HIV, and where similar prevention approaches are relevant. As the HIV/AIDS pandemic is more or less mature in each country within the area, a transfer of experience and expertise is desirable and possible from hardest-hit countries (Thailand, India) to others where the pandemic is only at its early stage (Laos, Cambodia, Indonesia). This subregional initiative has significant merits. In particular, building on cultural and historical roots of affinity among people, it creates bridges and stimulates a productive dialogue between countries on culturally and politically sensitive HIV/AIDS issues. **The Team recommends that the Area of Affinity approach be replicated and further supported by AIDSCAP, the USAID missions, regional offices and USAID/W.**

4. Sustainability

The evaluation team found that in countries where there is an active economy and a political commitment (i.e. Brazil, Thailand and Jamaica) the sustainability of AIDSCAP supported projects beyond AIDSCAP's life span could be reasonably anticipated. In these countries, the replication of models supported by AIDSCAP and their funding in the medium term will rely on the commitment expressed formally or informally by local governments and/or other entities (The World Bank in Brazil, the local USAID mission in Jamaica). The situation in Kenya and Senegal is, however, more problematic. In these countries in particular, it is difficult to envisage sustainability other than through strengthening of community and non-governmental organizations and through negotiation with the private sector and other bilateral or multilateral donor agencies of a better distribution of the burden of assistance.

The sharing and coordination of assistance will be of particular importance for AIDSCAP in the areas of condom procurement and STD treatments because AIDSCAP is actively involved in creating a demand for these commodities and because there is a risk of compromising these strategies if the commodities are not available.

During the remainder of its current contract, AIDSCAP should plan methodically for a transfer of experience, expertise, as well as management and technical materials it has developed, to governmental and non-governmental groups participating in HIV/AIDS prevention and care programs. AIDSCAP could achieve this through the conduct of national workshops on management and technical issues. It could extend its collaboration to NGOs/PVOs with which it does not have a collaborative relationship at present in order to enhance the capacity of these groups to design, implement, monitor and evaluate projects and prepare grant applications.

5. Technical Support

AIDSCAP extends its technical support to subprojects in several complementary ways. On request, it provides direct support to subprojects through staff based in countries , regional offices and HQ. AIDSCAP also provides technical support through its US-based subcontractors and, where possible, through local consultants. In several countries, subagreements have been created with local groups or institutions to assist subprojects in the areas of management and in each of the priority strategies. Technical support is extended at every stage of subproject development and implementation: needs assessment, design, training, monitoring, evaluation and research.

The Team performed site visits and interviewed managers and staff of almost every subproject, staff and consultants of sub-contractors (PATH, PSI and JSI) and local consultants in the five countries visited. It reviewed technical visit reports and assessed the timeliness, quality and impact of responses to requests for technical support. The Team was impressed with the quality and dedication of the staff deployed by AIDSCAP in the countries visited. Both expatriate and national staff were professionally well qualified and very cognizant of progress achieved and constraints met by each subproject. They had developed close ties with counterparts implementing subprojects from whom they had gained confidence and trust. The extent to which requests for technical support emanated from subprojects varied considerably from country to country and region to region. In Jamaica, requests were few, given the advanced stage of national HIV/AIDS program within which AIDSCAP's work is tightly integrated and considering the high quality of technical expertise available within the NAP itself and, more generally, in the country. In Thailand, subproject sites were visited by AIDSCAP staff twice a month and technical support extended through AIDSCAP staff based at the Thailand program and Regional offices within one week of request. In Brazil,

weekly visits to most subprojects—most of which were at their early implementation stage—led to the early identification of technical support needs and response to these needs. In Kenya, country office staff regularly visit the NGO consortium and subproject sites, and technical support is extended to projects conducted by the business community. In Senegal, technical support is given to the Health Education office of the Ministry of Health and to the STD and surveillance units. AIDSCAP had also drawn on sources of local expertise from NGOs/PVOs, for example: PDA in Thailand; ABBIA in Brazil; the Jamaican Medical Association in Jamaica; ACI end ENDA in Senegal. It has established collaborative relationship with local academic institutions: the University of Sao Paolo in Brazil; Mahidol University in Bangkok and the University of the Caribbean in Jamaica. Such links are less clear in Kenya and Senegal, but contracts are signed with researchers holding academic appointments.

The technical input provided by consultants, both from within and outside project countries, was consistent with strategies laid out by AIDSCAP Technical Working Groups, relevant to the needs of subprojects and reflected in further subproject development. The benefits of technical support extended by AIDSCAP to priority countries extends beyond the development of subprojects. A heavy demand was placed on the AIDSCAP Regional offices for the provision of technical support to associate countries. By the end of 1994, the Regional Offices had provided some form of technical support to 12 associate countries in Africa, 9 in LAC and 12 in Asia. These demands originated from USAID Missions with expectations on their part of a rapid response from AIDSCAP. There are clear advantages in AIDSCAP providing such support to USAID programs in associate countries, which is in line with its scope of work: (1) there is a transfer of experience and materials from priority to associate countries; (2) programs developed in associate countries incorporate sound strategies; and (3) it stimulate regional/subregional networking among groups and individuals working on AIDS within AIDSCAP countries of operation. This demand exercise a heavy pressure on AIDSCAP regional offices, however, in particular those for Africa and Asia.

The Team believes that AIDSCAP should now consolidate its work in priority countries and in associate countries where commitments have already been made. It should refrain from engaging in new country programs or projects. In order to facilitate the access by USAID missions to alternate sources of expertise, AIDSCAP should be prepared to recommend groups that can extend quality technical support to countries and facilitate their work by making available to them AIDSCAP guidelines and other technical materials.

Some flexibility should be applied to this recommendation. For example, AIDSCAP should still be prepared to extend its support to new subprojects in its present countries of operation if such subprojects are essential to ensuring the comprehensiveness of ongoing work or if they are intended to generate, through evaluation and research, essential elements of knowledge that may be critical to the success of AIDSCAP supported activities in a particular country. However, in line with the reasoning behind the recommendation above, any requests for new project starts should be reviewed with great care.

In several countries, AIDSCAP expertise has contributed directly and indirectly to the strengthening of state/national programs and to NGO/PVOs. In Brazil JSI, initially involved in logistic aspects of condom and drug supply within the AIDSCAP area of operations, was invited by the National AIDS Program to collaborate in the development of a national logistic scheme. The University of Antwerp group played a significant role in the development of state/national level STD case management in Brazil and was reported to have played a similar role in Ethiopia, Cameroon and Tanzania.

Overall, AIDSCAP technical input to subprojects and country programs has been timely and of good quality. It seemed to the Team, however, that the capacity of AIDSCAP staff to respond to demands for technical support is already being stretched and that there would be important person-power implications involved in increased demands for technical assistance.

6. Participation in "Global Learning"

AIDSCAP is engaged in a process of information and experience exchange through formal and informal mechanisms. This information dissemination strategy has the goal of strengthening awareness and support for HIV/AIDS prevention efforts, including AIDSCAP projects, in developing countries. The target audiences of the information dissemination are US policy makers, domestic and international HIV/AIDS communities, cooperating agencies in developing countries, USAID missions, domestic and international media. Tactics employed by AIDSCAP include distribution of materials, organization of conferences and educational meetings with policy makers, visit to AIDSCAP projects for policy makers, information sharing meetings with HIV/AIDS communities, pitching stories to the media and arranging special events to publicize prevention efforts.

A review of publications, presentations, workshops and events attended or organized shows regular participation in major international and regional conferences on HIV/AIDS. AIDSCAP staff and consultants have published articles in major international journals (i.e. Lancet and New England Journal of Medicine) as well as in local/national publications.

Materials developed by AIDSCAP are, however, not systematically brought to the knowledge of other AIDSCAP projects in a same region or in other regions where they could be used. For instance, in Thailand, a project with the Bangkok Municipal Authority has produced a tri-dimensional model of the female pelvic area which has proved to be effective in educating sex workers about sexual anatomy, physiology and sexually transmitted diseases. AIDSCAP projects in other countries visited were not aware that such a model existed and expressed their keen interest in having it made available to them. An AIDSCAP project in Thailand successfully working with pharmacists was unknown to AIDSCAP personnel in Senegal who were contemplating a similar approach.

The Team recommends that AIDSCAP should continue to disseminate widely the experience arising from its projects, including case studies and short narratives on empirically observed successes and failings encountered in the course of project implementation that will enhance the replication of successful approaches. More attention should be paid to the Intra-AIDSCAP dissemination of experience and lessons learned.

7. Linkages

The AIDSCAP project has established a solid network of linkages at headquarters, regional and country levels. Overall these linkages have been established with a variety of "traditional" players involved in the field of HIV such as NAPs, Ministries of Health, local government and administration, NGOs/PVOs (both indigenous and international), the private sector (through prevention activities in the workplace), other bilateral donors (CIDA, SIDA, GTZ, Cooperation Francaise...) and multi-lateral agencies (WHO, UNDP, UNICEF, World Bank, European Union...). These linkages are generating fruitful exchanges which should provide a positive underpinning to the further efforts in international coordination recommended below (Management).

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III. Operations and Management

A. Operations

Most of the questions in the Team's scope of work dealing with operations are covered in the other sections of this report. Two principal questions will be covered here: 1) the Program's adherence to its planned schedule and b) the change "in mid- stream" from a Cooperative Agreement to a Contract as the basic document controlling the Program. The two are closely related.

1. Schedule

Overall the Program is about one year behind its planned schedule. This is reflected both in the overall expenditure rate for the Program and in the fact that most sub-projects started under this Program are just now coming on-line or have been in operation for too short a period to permit of evaluation. The more "mature" projects viewed by the Evaluation Team were those that had been started under the AIDSTECH and AIDSCOM programs and subsumed under AIDSCAP.

In the Team's view there are several reasons for this, the principal one being the delays caused by the switch, about two-and-one-half years into program execution, from a cooperative agreement under which the Program originally was governed to a contract. This will be discussed below.

There have been other causes of delay, however. Foremost among these were the difficulties encountered by AIDSCAP and USAID in identifying an African base for the Program and what appears to the Team to have been a badly managed move into Nairobi once arrangements had been made to have USAID and the Government of Kenya accept its being based there. The Team has heard various conflicting versions of the initial attempt to base AIDSCAP/AFRICA in Harare; it cannot judge - nor need it - who was "at fault" (if anyone) for that problem. It does appear, however, that at least one element in that problem was the bad feeling between the African Missions and AIDSCAP arising out of the formers' feelings that AIDSCAP had been "imposed" on them. (This will be dealt with further below.)

In any event, Africa is too far away to be operated successfully out of Washington and this caused delays in getting sub-projects started. It also caused turnover in some critical staff positions; the Team was told that many people who had been chosen for management positions in the Africa operation backed out when they were told they would have to work out of Washington, albeit temporarily.

The move into Nairobi was another story. The Team was told that household effects, personal vehicles and project commodities were shipped and arrived in country before legal arrangements had been made with the Government of Kenya for customs exemptions and other legal niceties necessary for AIDSCAP to work in that country. In the event, it was necessary to get REDSO deeply involved in making the arrangements that should have been made, in advance, by AIDSCAP. All of this also caused operational delays, as might be imagined, as staff members were preoccupied with their own logistical problems.

The above having been noted, the Team also is of the opinion that the original timeline set out for this Program probably was overly optimistic to begin with. It seems to have assumed that the Program would be on the ground and running from Day 1. In this, the Programs designers may have counted too heavily on the presence, in a number of countries, of FHI as the operator of the AIDSTECH program. But AIDSCAP was much more than simply a continuation of AIDSTECH; it was a much more complex program. Further, the original schedule does not seem to have allowed for unforeseen circumstances. But unforeseen circumstances can always be foreseen in a program of this scope and complexity; only the **nature** of such circumstances must await the future to be revealed.

2. Cooperative Agreement to Contract

Effective February 3, 1994 - about two-and-a half years after the AIDSCAP Program was started under a cooperative agreement, the program authorizing document (vis-a-vis Family Health International, the implementing organization) was changed to a contract. This required changes in a series of AIDSCAP's day-to-day operations, most critical of which were changes in sub-agreements submitted for approval but not yet approved and changes in relatively minor operational and accounting details which, however, had to be redesigned and for which AIDSCAP staff needed to be retrained. A number of these changes caused Project delays ranging from weeks to over one year. The most egregious example found by the Team was in Senegal where, the Team was told, PIO/T's sent up through the Programs multi-tiered approval process by the Country Office in Senegal were caught in Washington by the switch and were not returned to Senegal for over one year. The Thailand Mass Media Subcontract had been delayed for 8 months at the time of Team's visit and was still in Washington upon our return. A more complete listing of sub-project delays reported to the Team will be found in Annex _.

While it is impossible to compute total time lost due to this shift, it is the Team's opinion that the shift was the single most important factor delaying Program implementation.

Further, the Team agrees that the conversion to the contract certainly had an impact on Program costs. This would be found, for example, in the costs incurred in redesigning and installing replacement systems necessitated by the conversion and in retraining staff, all of which had to be carried out from Washington. Time lost in program execution also had costs although they would be harder to quantify.

It seems to the Team that this Program could have been carried out - from an operational point of view - just as readily under either a cooperative agreement or a contract.[1] Be that as it may, the shift from cooperative agreement to contract was mandated with no concern for its impact on program operations - a sort of "That's not my table" attitude on the part of the Contracts Office.

This matter is now in the past - except for its impact on Program timing, although it should be added that the Team found some lingering confusion in the field - both USAID and AIDSCAP - about the operational implications of the conversion. In the event, the required changes were made and the Program is now operating smoothly enough under the new

[1]. The Team would be presumptuous to attempt to pass judgement on the contract law question of whether the change actually was required as a matter of law. We would note, however, information given to us by USAID to the effect that when the Contract Office sought to effectuate the same type of change in the case of other cooperative agreements - under the same rationale as that followed in the AIDSCAP case - the USAID General Counsel's Office ruled that the changes were not necessary.

procedures. And although the Team's scope of work refers to the change as "a change in direction", the shift does not seem to have produced any change in direction but only a change in documentation. The one change that was noticed was that, whereas the shift to contract mode was supposed to have assured USAID closer control of the Program, in fact, at the field level, it might have had a slightly opposite tendency. USAID personnel deal with contractor personnel in a distinctly arm's-length manner, quite unlike the more open, interactive relationships they have with personnel of a cooperating grantee. The Team saw evidence in some countries that this change in relationships had occurred. Thus, for example, many USAID personnel were chary of seeking the advice of AIDSCAP technical staff on program directions since that might have constituted a conflict of interests.

B. Management

1. Staffing

FHI/AIDSCAP is a highly centralized organization. Of its 101 technical employees, 40 are stationed in Washington while the balance - 61 - are overseas, distributed among two Regional Offices (Bangkok and Nairobi; the Regional Office for LAC is headquartered in Washington) and in 15 Priority Countries and 5 Associate Countries. This same approximate pattern is seen in the stationing of FHI's administrative personnel, with 62 in Washington and 106 overseas. This heavy concentration of staff in Washington reflects the highly centralized design of the Project, about which more will be said below. [For the moment the Team only will note that the picture presented is one of a highly centralized operation (AIDSCAP) interacting with a highly decentralized operation (USAID) and that managing that kind of set-up requires a *very* high degree of management skill.]

During the course of the Team's in-country interviews questions arose in our collective mind about the adequacy of staffing levels to carry out contract goals and objectives in the Regional and Country Offices visited. For example, the Country Office in Senegal appears clearly to be understaffed by at least one professional position. The section on Financial Management below suggests other areas in which additional staffing should be considered. The proof of the pudding here may be that contract goals and objectives are being met with the present staff. However, the Team did find several cases where high stress levels would seem to indicate that AIDSCAP management needs to pay more attention to individual work-loads to be sure they are not excessive and this could have implications for additional staffing needs. No examples of over-staffing were noted. Planning is underway in both Asia and Africa to incorporate several more Associate Country programs into the Project. Realization of such plans would, of course, require additional personnel.

The ratio of administrative personnel to technical personnel - 62:40 - at the Washington level and 106:61 in the field appears appropriate. (It should be noted that "administrative" and "technical" do <u>not</u> correspond to "support staff" and "professional" as those terms normally are used within USAID. For example, accountants and financial advisors are classified here as administrative personnel as are a number of the senior executives in the Washington office.)

AIDSCAP utilizes a "three echelon" system for the provision of technical assistance to subprojects and of management assistance to field offices. First recourse is to the Country Offices. Regional Offices provide a second echelon of support, providing assistance that Country Offices cannot provide on their own. If technical or managerial support beyond the capabilities of the Regional Offices are needed they are provided from Headquarters. Based on interviews and trip reports examined by the Team this system appears to be working reasonably well. We noted, however, that there were, inevitably, time lags between requests

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for assistance and the provision of that assistance. These lags amounted to some weeks in the case of provision of assistance from Regional Offices to Country Offices (particularly in Africa) and often of many weeks when the assistance requested had to be furnished by Headquarters. We also noted cases in which Regional Office personnel had spent more than 50% of their time "on the road" (also in Africa).

While the "Three-echelon" system described above undoubtedly saves money, as opposed to the cost of basing additional personnel overseas with all the attendant expenses that entails, the Team feels constrained to raise the question of whether a more "forward based" staffing strategy (i.e. fewer people in Washington, more in Regional Office and Country Offices) might not pay off in terms of (1) faster provision of needed support and (2) taking some of the strain off of Regional Office personnel, thus enhancing their productivity. This would seem to be particularly true in the case of financial management personnel (see the discussion under the financial management section below) but it also applies to technical and project management personnel. In the latter category we would mention particularly the need for "contract officers" - professionals who understand USAID and AIDSCAP contracting requirements and can help Country Offices draft contracts/sub-agreements.

The Evaluation Team's review of *curricula vitae* of both Washington and field staff indicated that professional staff, American as well as third-country and local nationals, are well trained and qualified for the positions occupied. Our interviews indicated that they are highly dedicated. In general morale seems quite high.

Office space occupied by Project personnel, both in Washington and in the field offices visited, is deemed to be appropriate. Indeed, although the Evaluation Team did not, of course, do a comparative study of real estate prices, all offices visited appeared to be well away from the "high rent districts" in their localities. The Country Office in Senegal is housed in a compound also housing the National AIDS office and other international participants in the fight against the epidemic in that country. There appeared to be adequate space for efficient operations but in no case observed did the space occupied seem to be either in excess of that required nor unduly lavish in furnishing or decoration. In both Bangkok and Nairobi the offices of the Country Officer for the country involved is co-located with the Regional Office. In Nairobi FHI/AIDSCAP is collocated with other FHI offices carrying out separate programs in the region. We were assured, however, that AIDSCAP personnel have no responsibilities for these other operations.

2. Turnover

As requested, the Evaluation Team also examined AIDSCAP turnover rates. According to information supplied by AIDSCAP for positions at grades 3 through 10, cumulative turnover rates for the period 1991 to 1994 by Division/Region varied from a high of 51.9% (Tech. Support Division) to a low of 36.4% (Africa Region). These translate into *annual* rates of 17.3% and 12.1% respectively. The overall cumulative turnover rate was 45.5% for the total period or 15.2% annualized.

The Team did not have access to statistics against which to compare these turnover rates. Indeed, it would be difficult to determine what turnover statistics might be truly "comparable", i.e. what category of organizations might provide a basis for judging whether the turnover rates experience by AIDSCAP are high, low or normal for an organization of its type. Accordingly, we would simply note our *impression* that Washington-based organizations set up to carry out long term (but indefinite) USAID contracts (both for-profit and NGO's) are characterized by a high degree of job-hopping, in and out, as temporary incumbents seek experience on which to base applications for more permanent development assignments.

Based on this admittedly impressionistic view, an annual turnover rate of 15.2% does not seem to be out of line.

More to the point is the question of whether the turnover rate "has had an impact on Project implementation". The Team has come across only one instance in which this might seem to be the case. Anomolously, this was reported to us by the Africa Regional Office, the AIDSCAP operation which actually had the *lowest* turnover rate. That Regional Office reported to us that Project implementation was delayed by the fact that a number of individuals recruited for in-country operations resigned when it became apparent that, pending arrangements for the establishment of an African office would be delayed. The individuals involved, we were told, did not want to work out of a Washington office having counted on posts in some African country.

3. Program Structures and Interactions

a. Intra-AIDSCAP

The Evaluation Team examined the organizational and operational structure of the Program to determine whether they facilitate or hinder the accomplishment of Program goals and objectives. As indicated above the Program structure is highly centralized, a design mode dictating AIDSCAP staffing. Under the USAID/FHI contract establishing the Project some 21 actions or decisions must be referred back to Washington (AIDSCAP and USAID) for approval. These range from actions which would change a budget line item by more than 15% to consideration of new proposals for sub-contractors/sub-grantees to the use of Third Country or Cooperating Country nationals in providing technical assistance.

In at least two respects we believe this high degree of centralization impedes the accomplishment of Program goals and objectives. One of these involves relationships with USAID Missions, about which more will be said below. The other, and more important, respect in which centralization impacts on Program operations is in the multi-tiered level of approvals required for even quite routine actions - such as approval of sub-contract and sub-grants - which add weeks and in some cases months - to implementation actions. Country Offices submit documents to the Regional Office which reviews them and sends them on to Washington, where they are approved, or revised, by both AIDSCAP/W and USAID/W. USAID Mission concurrences, where they are necessary, are obtained either before or after Washington approval. In some cases the USAID Mission "chops off" twice, both going and coming. It should be stated emphatically that this is not a "fault" of AIDSCAP operations. In the Team's view, it is a fault of program design. AIDSCAP/W approvals parallel the USAID/W approvals that are required under the contract. Thus, a change in the system probably would require amendment of the basic contract.

That having been said, and with the exception of one or two minor "glitches" which the Evaluation Team regards as inevitable in an operation of this size and scope, the FHI/AIDSCAP relations among constituent units appear to be smooth. This applies both to intra-headquarters relationships and to those between headquarters and field operations. The Team's many conversations at all levels discovered no cases either of significant differences on policy or operational matters or of other sorts of intra-organizational discord. Staff in all Washington divisions and in the field are "singing from the same sheet of music". With the possible exception of financial management (see Section IV below) policy and operational direction flow smoothly from headquarters to field units. The information flow from the field to headquarters also appears to be carried out in a timely and satisfactory manner.

The Team noted that some Implementing Agency reports have been submitted late and that this apparently has caused some temporary discrepancies between data supplied by FHI/AIDSCAP to USAID and subsequently published "true" figures. While FHI/AIDSCAP should continue to seek timely reporting from its Implementing Agencies we do not regard this as a serious problem in its present dimensions (and, indeed, we know of no proven technique for assuring that all Implementing Agencies report on time all the time).

The Team does, however, question the number of substantive (as opposed to financial) periodic reports required of Country Offices and Regional Offices. While we didn't count them, our reading of a substantial number of them raised questions in our minds about the need for much of the data being submitted. This impression was enhanced by our inability to determine, despite repeated requests, who in Washington gets this information and what is done with it. In part we suspect this volume of reporting is a function of the highly centralized nature of this Project and a desire by AIDSCAP/W and USAID/W managers to stay on top of events in the field. The Evaluation Team also has the impression that either FHI/AIDSCAP or USAID/W (or both) want to be prepared to provide fast answers to almost any question anyone might ask about any aspect of the Program. While we can understand why this might be so given the many sensitivities involved here, we are led to question, based on our interviews in the field, whether this "universal" approach to information gathering is being adequately balanced against the time it *takes away* from the essential business of operating programs.

b. Relationships with USAID

Interactions among FHI/AIDSCAP and USAID present a somewhat different picture. Interactions between FHI/AIDSCAP and USAID at the Washington level do not appear to present any problems. Team interviews and our document review indicate a high degree of accord, between the two organizations at the headquarters level. ("Headquarters", in this case, refers to G/PHN/HN/HIV-AIDS, the organizational unit within USAID/W with immediate operational responsibility for the Project). Also, the Team's interviews with USAID's Regional Bureaus did not bring to light any relationship problems at that level.

Interactions at the field level - i.e. between AIDSCAP regional and country offices and USAID Regional Offices and country Missions - present a different picture.[2] In general, USAID Missions and Regional Offices gave AIDSCAP mixed reviews. The Missions in Brazil and Jamaica got along fine with AIDSCAP in the field, although this feeling did not necessarily extend to AIDSCAP/Washington (including the Regional Office for Latin America and the Caribbean which is headquartered in Washington). In Africa, judging from our limited sample, relationships between USAID and AIDSCAP were - to state matter baldly - bad.

While there may be several reasons for this as among the various countries visited in the course of this study, there is one overarching reason in the Team's view. The fact that USAID's field offices were not consulted in the original design of the AIDSCAP Program (they **have been** consulted on AIDSCAP plans in their countries) led to a still-lingering resentment and a feeling that AIDSCAP is just another attempt by Washington to impose a program on them for which they then are to be responsible without having had any input. This works out in various ways, none of them conducive to the fullest possible success of the AIDSCAP Program or even to its full potential utilization by USAID Missions or Regional Offices. For one thing, for example, AIDSCAP is widely blamed for delays and/or "inflexibility" (largely

[2]. The Evaluation Team wishes to note its regret that it was not able to hold a planned interview with RSM/Bangkok and that further attempts to elicit comments from that office were unsuccessful.

inability to accommodate various Mission requests for assistance) which, rather than being AIDSCAP's "fault" result, in the Team's view, from the design of the Program. This is linked to the fact that many Missions have designed and are carrying out their own AIDS programs and either seek assistance from AIDSCAP that AIDSCAP is not in a position to supply or even see AIDSCAP as a competitor for resources and/or a competing source of policy advise to host country officials that the USAIDs cannot control. Indeed, the question of "who's in charge" looms large in the minds of many USAID officials interviewed in the field. This is the principal manifestation of the problem noted above of a highly centralized operation (the AIDSCAP Program) interacting with a highly decentralized operation (USAID).

There are other, localized factors that contribute to the relationship problems noted. Foremost among these was AIDSCAP's unaccountably difficult entry into Kenya which involved the expenditure by REDSO of large amounts of staff time and political capital. In at least two other countries the Team found what appeared to be personality clashes - emanating in both cases from USAID - between USAID and AIDSCAP officials. While such clashes probably are inevitable in a program of this size and scope they do impede project success both in intrinsic terms and in terms of the full utilization of Project resources by the USAID Missions involved. The solution to this problem probably lies in a full, if belated, dialogue with USAID Missions about what they want from AIDSCAP and what AIDSCAP is set up to provide to them, probably with some modification of the Project, as necessary, to take the field's views more fully into account.

c. Linkages; International Cooperation

The Team also looked at USAID relationships with the UN and other multilateral and bilateral "players" in terms of efforts to garner effective support for the Project, to improve coordination with those other agencies and to be sure that lessons learned under the Project were being disseminated to these other agencies. While dissemination efforts are judged to be satisfactory (see the discussion above under Technical Aspects), overall liaison efforts leave room for improvement. Attempts at overall program coordination differ from country to country. In Kenya, through USAID's efforts, an AIDS Council of all AIDS donors has been put together and meets periodically. This is the only example the Team found of this kind of coordination effort. On the other hand all of the Missions visited reported at least occasional, ad hoc, meetings with other donors on specific problems. Further, while AIDSCAP offices do interact, on occasion, with other donors, the views of the Missions interviewed suggest that this is considered a matter under USAID jurisdiction and attempts by AIDSCAP in this direction constitute "encroachment". (In Kenya, for example, the AIDSCAP country representative is not generally invited to meetings of the AIDS donors committee.)

At the Washington project management level the view seems to prevail that coordination with other international donors is a field problem. The Team does not agree with that view. While *in country* coordination clearly must be managed at the field level, an overall framework for such efforts needs to be established at the headquarters level. This is not easy to do and, even when such arrangements are agreed to they are not automatically transmuted into field-level coordination efforts; however, without headquarters level agreements on overall roles and missions, how to avoid duplication and develop mutually-supporting and even synergistic interaction at the field level the latter will not come to pass on a broad scale.

The Team was informed that an effort was made within the past several years to hold a meeting of the Development Assistance Committee (DAC) of the OECD on AIDS but that the meeting was a failure. We have not been able to find out exactly what happened. If the Team's information is accurate this is an unfortunate circumstance, since the DAC would

seem to be the ideal forum both for marshalling international donor support for the AIDS effort (the World Bank, while not a member of the DAC, participates in its meetings) and for highlighting coordination problems and working out solutions.

If the circumstances surrounding the last DAC meeting on AIDS are deemed to preclude another attempt at such a meeting in the near future, attempts to achieve the same results will have to be undertaken on a bilateral basis at least with the principal international (including bi-lateral) actors in the field. While these contacts can be initiated at the Project Office level, to be effective they will have to involve USAID officials at the highest levels, probably including the Administrator. Only arrangements made at those levels will result in the kinds of instructions going to field personnel that will be taken seriously in the field.

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IV. Financial Management

A. Introduction

The term "financial management" as generally used by AID encompasses two areas -- *accounting* and *finance*. In its basic elements, *accounting* is the system by which receipts and disbursements are recorded and *finance* is the management and analysis of money. Although "financial management" is commonly used as the term for the finance aspects only, its meaning in this Report will be consistent with AID usage and will represent the combination of accounting and finance.

B. Accounting

1. The Accounting System

a. FHI/Headquarters Accounting System

Family Health International's (FHI's) accounting system segregates funding by source through a Cost Center system. Further segregation of add-on, OYB transfer and core funding is facilitated at AIDSCAP's Headquarters in Arlington through this system. Both field and home office costs for specific projects and activities by country are tracked through this Financial Cost Objectives (FCO) system. Each digit of the FCO number is an identifying marker of funding source, project component area, etc. In addition, Implementing Agencies (IA's) are subject to routine financial reporting as well as to internal audits at both FHI's and USAID's discretion.

b. Field Expenditure Tracking System

AIDSCAP did not implement an accounting system *per se* at the Regional and Country Offices. The FCO system has been transferred to the field to generate information on a global basis for Headquarters' own reporting requirements. Subproject budgeting and expense reporting is guided by the FHI accounting office which has provided all field offices with templates and report forms to facilitate reporting, though not financial planning.

An "expenditure tracking system" has been implemented project-wide instead. This system allows the field to track expenditures but does not provide management at the local level with the necessary detailed financial information it requires for decision making.

The tracking system puts heavy emphasis on fiscal control (cash control), rather than on efficiency and cash management. The system appears to have been developed primarily for "compliance budgeting" and other legal purposes as opposed to managerial purposes. AIDSCAP's expenditure tracking system as it was implemented in the field is based on satisfying Headquarter's reporting needs as opposed to the field's or both.

c. *Cash Based Accounting*

The expenditure tracking system is a cash basis system. Cash basis accounting indicates that all revenues are recognized when received and expenses are recognized when paid. This system is not useful in the exercise of control over expenditures or the generation of timely information which can be useful when adjustments or changes in program are required. AIDSCAP field offices require a system of financial information which can be used by the field managers as a tool for management of the project's resources and to make accurate and timely decisions.

d. *Internal Accounting Control*

Internal control can pose a real problem in countries were there is only a Resident Advisor or the staff in the accounting department is one person. Most Country Offices have just one finance person. In Associate Countries the Resident Advisors have to operate alone and therefore are charged with the total responsibility for the project including the financial responsibility.

Internal control procedures, such as requiring two signatories, (e.g., the RA and the Financial Manager, the usual model) are in place. There is also a separation of accounting responsibility within the finance departments where there is sufficient staff. The two-signatory system also is followed in most IA's, although this requirement may be waived in certain circumstances.

Internal accounting control comprises the plan of organization and all of the coordinate methods and measures adopted within an organization to safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency and encourage adherence to prescribed managerial policies.

Some characteristics that influence internal accounting control include:

- A limited number of staff or inadequately trained staff to provide the appropriate segregation of duties.

- In IA's, a mixture of volunteers and employees participating in operations. Depending on the size and other features of the organization, day-to-day operations sometimes are conducted by volunteers instead of employees. The manner in which responsibility and authority are delegated varies among organizations. This may affect control over financial transactions, particularly with respect to authorization.

2. Accountant's Handbook for the AIDSCAP Project

The Accountant's Handbook was issued by AIDSCAP/Headquarters in 1993. It provides information on the basic procedures and guidelines for the country office monthly financial reporting required by AIDSCAP/Headquarters.

In examining the Handbook, it is clear that its main purpose is to serve Headquarter's needs for reporting to USAID. It is the Team's understanding that the Handbook was developed in 1992 at the initiation of the project, but has not been formally revised or expanded since. It also is the Team's understanding that an updated version is in process.

The Handbook is divided into three parts. Parts I and II "Explanation of Accounting Forms" and "Annex of Accounting Forms" contain basic information on the books of account to be

maintained, vouchers and bank reconciliations, as well as the forms utilized in record keeping.

In Parts I and II, the Handbook also provides detailed instructions on how to deal with exchange rates and recommends the Weighted Monthly Average system for translating local currency into dollars for reporting purposes. However, the fact that fluctuations of currency usually come accompanied by inflation, or how to deal with that problem, are not mentioned in the instructions.

Part III, "Monthly Reporting Procedures" requires that a series of documents be sent to the Regional Finance Officer by express mail or DHL: Expenditure Summary Report; Journal Entry Form; Currency Exchange Calculation; Bank Reconciliations for each bank account; Accounts Payable Vouchers with supporting details for all payroll and fringe benefits; Accounts Payable Vouchers with supporting details for all allowances paid on behalf of expatriates and other employees including but not limited to housing, guard services, school fees, utilities, etc.; Certification form signed by Resident Advisor.

In addition, the Handbook suggests (on the same page) that "in order to facilitate and speed up reimbursement procedure for funds expended, the following forms may be faxed to the Regional Finance Officer: Expenditure Summary Report, Journal Entry Form, and Certification form signed by Resident Advisor.

That is a lot of documentation to be photocopied and mailed/remitted by the Country Offices. The Country Offices' use of express mail and/or DHL, and faxing the second set of documents to the Regional Offices and then to Headquarters monthly as suggested in the Handbook raises communications costs significantly.

In the General Information section the Handbook presents a description of FHI's Chart of Accounts with detail codes, FCO Codes and FCO monitors.

A series of memoranda and attachments have been sent by Headquarters to the Regional and Country Offices which could be considered part of the Handbook:

- a description of the new "FCO numbering System' dated August 10, 1992 is also included. It is the Team's understanding that the revised Handbook will include a "reconciliation report" on a macro-level.
- Guidance for Charging Staff Time.
- Vehicle & Capital Equipment Purchases Rules.
- Subagreement pre-award financial review & assessment procedures.
- Suggested Guide for Financial Review and Assessments.

Internal control issues set out in the Handbook appear to leave some gaps. A case in point is the procedures developed for Unit and Health Posts. As is explained throughout the Handbook, the fee collector-payer also prepares the invoice, collects the funds, prepares the financial reports, deposits the funds in the bank, and maintains the books where fees collected are to be registered (Page 5, Item 1). The question is: Who supervises this individual and how can one ensure that the information presented in both the financial reports and the books is a truthful account of the fees collected?

3. Accountability for Fixed Assets

The accounting control of fixed assets appears in the Accountant's Handbook as "Schedule of Project Inventory". The Handbook form requires that the following information be recorded: purchase date, quantity, unit price, description, estimated life, and US dollar purchase cost. Please note that field fixed assets do not carry any type of insurance. If there is a fire, theft or loss, AIDSCAP would probably have to incur the expense of replacing those assets.

To maintain accounting control over capital assets, a Fixed Asset Register should be maintained as part of the general accounting records. Some items of equipment should be treated as individual units within the Fixed Asset register when their nature and unit cost justify such treatment.

Other items of equipment, if they are similar and are used in a single cost center, may be grouped together and treated as a single unit within the register. The Fixed Asset Register should be segregated by cost center so that the cost of machinery and equipment and the related depreciation for each center is available. In the Team's view, the amount of information requested in the Handbook is not sufficient.

4. Budgeting

a. The Budgeting Function and Process

Salary information is not available to field personnel responsible for preparing budgets. As a result, there sometimes is a need to circulate the field's budget several times between AIDSCAP/Headquarters and the field. According to interviews in the field, salaries at AIDSCAP are accorded a high degree of secrecy and only very few individuals within the organization have access to this information. The Regional and Country Office managers are not among those who have access to salary information about their own staffs.

Budgets are prepared by the field leaving blank spaces for salaries and consultants' remuneration. AIDSCAP/Headquarters requires that the field present "level of effort" calculations which are then sent to FHI/North Carolina Central Office for calculation of "personnel projected costs" based on the salaries already placed on FHI's Central Office computer. That information is inserted, in a lump sum, by AIDSCAP/Headquarters or the Central Office in North Carolina and retransmitted to the field. Accommodating to the final figure received, the Team was told, sometimes requires a further round of budget negotiations between Country or Regional Offices and AIDSCAP HQ.

This procedure also raises the question, in the Team's collective mind, of what influence, not to say control, is excercized by Managers and Supervisor at AIDSCAP over the remuneration of the staff they supervise. In any event, it stands as a stark monument to the centralist philosophy under which AIDSCAP operates.

b. Budget Performance

Despite AIDSCAP's efforts to maintain budgets at all levels within the prescribed limits, there is a tendency in the project at all levels to either over-budget or under-budget. Another persistent set of problems identified by the Team are those of running deficits either in the total budget or on individual budget line items or of incurring expenditures in line items not budgeted.

Some examples of the above are:

- The Behavioral Research Budget for 1994 was projected at US$1,763,831 of which US$1,115,592 or 63.2% had been spent to the date of the Team's review, early in FY 1995. A balance of US$648,239 remained in the budget.

- The 1994 HIV Counseling and Testing budget was projected at US$445,646. To the date of this review, US$214,413 or 48% had been spent. A balance of US$231,233 remained in the budget.

Actual expenditure exceeded budgeted amounts in the following items:

- BRU w/o projects budgeted $404,709; actual expense $687,478; deficit ($282,769)

- Individual budget line items with non-budgeted expenditures were:

  — Salaries $17,199; CPA $2,751; Fringe $5,187; Domestic Travel $2,365; Contract Labor $4,962. For Foreign Travel, the budget was $35,366. The actual expenditure was $44,192 or 25% more than budgeted.

Implementing Agencies also exceeded amounts budgeted in various instances. In others, when one analyzes individual field project expenditures to date and projects total expenditure at end of project based on average monthly expenditures to date (admittedly not the most accurate method of determining EOP costs), in almost every instance the result is an over-projection of expenditures. This situation was found in all regions.

These findings raise two questions in the Team's view. First, FHI/AIDSCAP's budgeting procedures need to be reviewed and overhauled with a view to keeping a closer watch on budget and expenditure projections. Second, it seems likely to the Team that there is more money remaining in the AIDSCAP budget than is shown by current projections.

5. External Audits

FHI has contracted with the accounting firm of Ernst & Young to carry out their external audit program. These external audits are being carried out on a regular basis. Audit findings need not be repeated here since they are made available to USAID.

The required OMB A-133 audit program is administered by FHI in their North Carolina Internal Audit Department and information on follow-up action is maintained there.

There are currently ten (10) IAs in all regions with questioned costs. Correspondence was sent to the COs requesting that follow-up be done and instructing the Regional Offices on procedures to do so. The final results of the follow-up, which would consist of determining the status of implementation on recommendations issued by Ernst & Young, are not available as yet. That exercise was still in process at the time of this review.

Although the 1993 audits were issued with unqualified opinions, the observations made by the external auditors in general ranged from weaknesses in internal control and incorrect classification of expenses, to breach of contract.

The Team noticed that in instances of disallowing expenditures and appropriate management and use of interest earned from AIDSCAP's funds there is extreme leniency on the part of

FHI's external audit department. There are very specific provisions and controls established by AID in this area.

6. Centralization/Decentralization

Some in the field, including but not limited to some USAID Missions, perceive FHI/AIDSCAP as a big bureaucracy, very top heavy, very centralized, and as an entity where very little decision making is delegated to the Region and even less to the Country representatives. In the financial management area specifically, the perception is that Headquarters has been suffering from a significant amount of confusion in the interpretation of AID's rules and regulations, particularly produced by the conversion from a Cooperative Agreement to a Contract. Although some feel that centralization was always part of FHI's corporate culture, even when AIDSCAP was under the Cooperative Agreement, some feel that the situation worsened when AIDSCAP was converted to a Contract.

A USAID Mission's cable to the evaluation team said: "it is difficult for the local staff to maintain their swat team mentality fighting through the morass of regional and international paperwork and attendant delays. AIDSCAP management urgently needs to make serious strides towards decentralization, and must emphasize the importance of having a responsive organization which can move quickly and creatively in the fight against AIDS". The Team agrees with that conclusion if not necessarily with the colorful characterization.

C. Project Financial Management

1. Reports and Financial Analysis

There appears to be a certain dependence on FHI/North Carolina for financial information that is or should be readily available at the Program's headquarters in Arlington.

The Team found that some cost data needed to comply with the Mid-Term Evaluation Scope of Work was not readily or easily available from AIDSCAP. This may be an indication that the FHI system gathers information that strictly conforms to the kind of financial information that would be required to satisfy its contractual requirements and not financial information that could be appropriate to manage the project's finances. However, it is also important to note that not all information needed for the Mid-Term Evaluation Scope of Work is necessary for the financial management of the project.

2. Cash Management

a. Cash Flow Projections/Management

Resource management is different from resource allocation in that it includes accountability for results. Resources are becoming scarcer so waste must be eliminated, by eliminating inefficient and ineffective use of resources and improving the budgeting system by making more accurate projections and improving forecasting.

In attempting to respond to this challenge, AIDSCAP's projects in the field are immediately confronted with the lack of details, relevant information about expected resource requirements, the actual resources utilized in the provision of health services, and the results.

Furthermore, the information needed to enforce accountability for variances from expected resources usage or expected results is lacking. Current conditions require that both Regional

and Country Office Managers be supported with better tools and better information for decision making.

b. Advances to Implementing Agencies and Field Offices

Currently there are approximately US$1,154,000 in outstanding advances to Implementing Agencies plus US$2,117,000 to Country and Regional Offices. In addition, a total of US$2,1-79,000 in reimbursements are in transit.

Advances to field offices, per AID Handbook 19, can only be given for thirty (30) days of cash needs, although with USAID's approval this period can be extended to ninety (90) days. The three (3) month advance AIDSCAP has until now made to Implementing Agencies violates the "advances" rules as described in AID Handbook 19.

c. Interest-Bearing Bank Accounts

Regional and Country Offices as well as Implementing Agencies in countries with inflationary economies have established procedures for retaining the value of AID funds. The most notable of these cases is that of Brazil.

The Brazil Country Office in 1993 was faced with the difficult task of maintaining the value of US dollar advances received from AIDSCAP in the face of Brazil's 35+% monthly inflation.

On November 30, 1993, Mr. Dick Goughnour USAID/Bolivia's Controller recommended, and the USAID representative approved, AIDSCAP's practice of depositing funds in interest bearing accounts as a measure of protection against inflation. On November 9, 1993, a letter was sent by AIDSCAP's Regional Financial Officer to AIDSCAP/Brazil confirming FHI's agreement with this practice.

It is important to note that this practice is technically against AID policy which requires that all interest earned on advances revert to the US Government. Furthermore, the interest earned in the accounts is presently being used to support project activities.

The Team noticed, though, that AIDSCAP's External Audit, via a memorandum from FHI's Manager of Internal Audit to the Jamaica Resident Advisor authorized one of the implementing agencies in Jamaica to keep $100 per year of the interest earned on FHI funds. Also, Mahidol University in Bangkok was told, in a letter from AIDSCAP dated September 20, 1994, that according to ".... sub-agreement terms the University is allow to keep $100 of the interest earned" in their interest bearing account".

These authorizations seem to have been made in response to an observation made by Ernst & Young that ".... income earned on FHI funds (by one of the implementing agencies) were not placed in the FHI account but incorporated in the general account...." of the agency in question.

In the Team's opinion, unless this authorization has been backed by an AID waiver, it is not valid.

D. Financial Management Support

1. Personnel

a. Finance Department at AIDSCAP Headquarters

The Finance Department at AIDSCAP/Headquarters office in Arlington has a staffed of sixteen including support staff.

During discussions with both the Director and the Finance Officer, the Team was informed of the complexity of their tasks particularly in what relates to labor issues and compliance with the contractual agreement in general. The Team came away with the feeling that the Finance Department's focus is on the intricacies of contract compliance and not on technical assistance to the field particularly when it comes to making any changes in accounting, e.g., implementing an accounting system in the field.

A quick look at the document setting out the roles and responsibilities of the Finance Department confirms the impression that the heavy concentration of the tasks of the finance staff is in ensuring conformity with US government and AID regulations. In the Team's view, while this is necessary it is not sufficient.

b. Finance Departments in the Field

Understandably, due to the centralized nature of the AIDSCAP project, two levels of performance of the finance departments in the field were identified during the five country visits: (1) either the department works in **isolation**, with few links to other regions and focuses on providing Headquarters with the information requested, making a minimal contribution to the rest of the project; or (2) the department was **reactive**, the classic "firefighting" technical function, responding to problems encountered by the rest of the organization but without its own long-term strategy.

c. Finance Staff Skills and Numbers

Numbers and skills vary among the various field offices visited to an extent which forces the Team to reiterate that, out of fifteen priority countries, only five were visited.

However, in cases such as Jamaica and some sub-projects in Brazil where AIDSCAP is working with the Ministry of Health and parastatals, instability, low remuneration, over-staffing, under-staffing and inadequate MOH personnel policies were cited as the major problems for those who are implementing the finance work under the Program. It is important to point out that those employed with the EPI Unit in Jamaica and who are paid by AIDSCAP are skilled and trained staff. However, the EPI Unit's director pointed out to the Team that the difficulties encountered by his team in operating with budgets from various donors, various salary levels, and various demands for reporting imposed by each donor contribute to fragmentation at MOH.

In the Asia and Africa Regional Offices and the Thailand, Kenya, and Senegal Country Offices, the finance staffs have sufficient knowledge to perform their functions. The major obstacle encountered by these staffs are the geographical distances of some of the IA's funded by AIDSCAP. This makes monitoring and delivery of technical assistance quite difficult for the Regional Office staff.

The field finance offices visited are run by 1 or 2 persons. All Country Office accountants visited and the Asia Regional Finance Officer have recognized the need for additional information beyond that provided in reports required by Headquarters and each has developed his/her own modified and/or additional reports which they and the Regional Director or Resident Advisors use to monitor costs. The Asia Financial Officer has also taken the initiative to learn about the FAR and AIDAR clauses associated with the Contracts. In Senegal, the Accountant and the Administrative Assistant have begun to develop their own project financial management and analysis tools. The Africa Regional Finance Officer has developed simplified standard forms (not part of the current Accountant's Handbook) to obtain consistent reporting from the Country Accountants in his region.

2. Training and Technical Assistance

a. Technical Assistance/Headquarters Support

The Team believes that AIDSCAP/Headquarters has concentrated on supplying the needs and requirements of USAID at the expense of supporting and improving systemic needs in the field. The field systems are donor driven; they were developed with the express purpose of satisfying the needs for information by Headquarters to USAID in the financial management area where several financial management problems and weaknesses have been identified. These include little attention being paid to mounting recurrent costs; no integration in financial management; no integration between program and finance; and an un-integrated financial management structure.

Cost information at a detailed level also is lacking in the system. Due to the lack of this important information on project/service costs management cannot make informed decisions regarding cost control, pricing and resource management.

While some technical assistance has been provided by AIDSCAP/Headquarters to the field in this important function of management, in the Team's view a lot remains to be done particularly in establishing an accounting system.

b. Technical Assistance and Monitoring

The TA provided by the AIDSCAP/HQ Finance Department seems to have been scattered and somewhat "helter-skelter. There does not seem to be a "plan of action" developed by Finance which includes a coherent TA plan for the Regional Offices.

The Team agrees with the Headquarters Finance Director that the project design intended financial technical assistance to be carried out from the Regional Offices and not from Headquarters. However, the Team believes that the ultimate responsibility to USAID for the success of the institutional strengthening part of the agreement rests with Headquarters. In addition, the responsibility for leadership and TA to the Regional Offices also rests with Headquarters.

Technical assistance carried out from AIDSCAP/W since initiation of the project consists of:

(a) "Summer 1993 - four weeks of technical assistance were provided to the South Africa program and the start up of the Africa regional office in Kenya".

(b) "November 1993 - Three weeks of assistance were provided in Bangkok, Thailand. The scope of work consisted of orientation and assistance to the newly hired regional finance officer (local hire) and resident advisor for the Nepal country program."

(c) "April 1994 - The Finance Officer attended the Africa regional meeting of Resident Advisors in Kenya (one week) and proceeded to provide additional assistance (two weeks) with the South Africa country office (training new accountant)."

(d) "June 1994 - Finance Director attended the meeting of the Asia Regional office and resident advisor staff (one week). The purpose was to provide orientation and information concerning the contract conversion."

(e) Concurrently with the preparation of this report the finance office was providing technical assistance to the Ethiopia country office program (2 weeks) and was to continue on to the regional office to provide assistance to the Regional Office.

(f) Additional assistance (up to six weeks) based on the priorities of the Africa Regional office will be provided during the first half of 1995.

In addition, a training seminar on accounting and finance topics for Resident Advisors was conducted in March 1993.

Beside the TA provided by the Headquarters finance staff, additional TA is provided by the Regional Finance Officers to Country Office Accountants on an ongoing basis. This is sometimes face-to-face, but more often telephonic, especially in the Africa region, when Country Office Accountants call with questions.

A stereotypical problem in this area appears to the Team to be encapsulated in a memorandum from USAID/Ethiopia's Chief Accountant to REDSO/ESA/PH dated August 29, 1994. The memo raised questions in several areas, including circumstances under which pre-ward assessments are required and commingling of funds. It highlights areas in which AIDSCAP's Africa Regional Office misunderstood contractual requirements on these and other points. The question is: Could this problem in Ethiopia have been avoided by more proactive training of regional and country staffs?

E. Financial Management as a Support Function

Financial Management as a support function to the technical area has not traditionally been a priority function in most development projects and the AIDSCAP project does not seem to be an exception.

Although AIDSCAP has developed information gathering instruments, and has worked with its field offices in the financial management area, a significant amount of strengthening remains to be done in the field in order for AIDSCAP to truly make a significant contribution in institution building at the IA level.

The systems for recording transactions that have been developed by AIDSCAP/Headquarters for the field are totally "donor driven systems", that is, they were developed to satisfy the needs for information of USAID. However, because of their previous experience in the field, finance staffs in the countries visited have expanded and upgraded the system of templates provided by FHI/AIDSCAP to fit her/his needs for detailed information which was lacking in the systems original version.

For example, the Finance Director in the Brazil Country Office developed a software model which responds to the Cos needs for internal and external reporting. The Finance Director in the Jamaica Field Office also developed a model. This model was given to an AIDSCAP/Headquarters staff member during a technical assistance visit in 1993 but no

response or comments were received. Neither one of the Directors knew about the system developed by the other.

In order for AIDSCAP to meaningfully contribute to strengthening field organizations in Financial Management, more time and resources would have to be employed both at headquarters and field levels in monitoring and delivering technical assistance. This does not necessarily mean that AIDSCAP needs to recruit additional staff, although this might be necessary. What is needed first, however, is to re-examine Headquarters and field finance staff's skills, and re-assign those who have demonstrated field performance or implementation skills, as opposed to just technical expertise, as the ones responsible for delivering technical assistance not just to subordinate levels of the AIDSCAP organization but also, most importantly, *to the Implementing Agencies.*

The focus purely on fiscal control should be modified. Financial Management should be a participatory function, and it should be proactive rather than reactive.

There should also be more interaction between the Headquarters at Arlington and the field offices financial staffs. AIDSCAP has placed qualified staff in its field offices although some more need for guidance and leadership from Finance/Headquarters would greatly help in enhancing those staff's skills.

Most of the individuals interviewed during the evaluation have already worked in AID projects or have worked in the development field in other organizations. Headquarters should take advantage of this wealth of experience in the field and polish these staff's skills for the benefit of the project.

More systematic communication between regions should also be encouraged by Finance/Headquarters by developing a mechanism that ensures exchange of ideas and experiences between the finance staffs in the field. The finance staffs in different regions were not aware that their peers were facing some of the same problems they were nor of the creative steps some of them have taken to solve those problems.

F. Capacity Building and Sustainability

1. Sustainability/Strengthening of AIDSCAP'S IA's

AIDSCAP Regional and Country Offices have provided technical assistance to Implementing Agencies in the financial management area. However, there is still a great deal of technical assistance needed at the IA level.

It is very difficult for the ROs and Cos to strengthen institutions when their main focus is in developing the best system to report to Headquarters and USAID. This focus pressures the field offices to pay less attention than they should to developing financial management capacity at the project implementation level.

The Team is of the opinion that the main focus of the field offices should be to increase the capacity of collaborating agencies to develop sustainability plans, both financial and programmatic, in the process of conducting HIV prevention activities among targeted populations.

Many of the IA's are very small. At the community level, accounting systems often do not exist. In Senegal (outside a few major cities), everything is on a cash basis. There are no

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receipts. There is no national banking system. Eighty percent (80%) of the population is illiterate. When a small community-based group in Senegal is involved in AIDSCAP, the notion of its complying immediately with AID and FHI rules and regulations is an impossibility. Capacity building must begin with basics which in other countries would be taken for granted.

2. Private Sector Leveraging

Business communities in some AIDSCAP countries are beginning to recognize the need to mobilize resources and have already taken the first step by requesting assistance from AIDSCAP to design and implement AIDS prevention programs in their workplaces.

In Thailand, Brazil, and Jamaica efforts are being made in this area. In Thailand, an IA has trained over 1100 peer leaders in 30 factories (as of September 1994), who then have small group meetings with their co-workers. AIDSCAP/Brazil hopes to create sufficient interest within large companies and labor unions for them to participate in AIDS prevention programs. In Jamaica, one large organization is already involved in a small program of this sort.

The leveraging activity will be evaluated on the amount of resources allocated on a semi-annual basis for AIDS prevention by the private sector organization(s) compared to the amount of resources utilized by AIDSCAP to initiate and monitor the activity.

3. Cost Sharing (Counterpart Funding)

This type of expenditures is difficult for the accountants to verify. The CO's have to rely on information provided to them by the agency sharing in the cost. In some cases the cost sharing consists of the provision of equipment or not charging indirect rates, both of which are easier to verify. In general, cost sharing information is more readily available at NGOs because NGOs tend to have better accounting systems. This is not normally the case in instances when the counterpart comes from a governmental agency.

Although there is cost sharing in other countries, such as Senegal, it is the Team's understanding from AIDSCAP that only Brazil and Jamaica are required to obtain counterpart funds from IA's. It is also the Team's understanding that the counterpart funding was initiated under the Cooperative Agreement and it remained after the Contract. Up to this date, the Team has not been able to obtain clarification from AID as to why Brazil and Jamaica were singled out as countries where counterpart funding should be obtained.

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V. Conclusions and Recommendations

A. Technical Aspects

1. BCC

The educational activities observed during country visits often emphasized the risk of STD/HIV infection and possible risk reduction methods but little emphasis was placed on sexuality as a pleasurable, normal function in people's life. **Further attempts should be made by AIDSCAP to explore the relevancy and extent to which sexuality, cast in a positive context of mutual trust and intimacy, could be introduced or emphasized further in communication strategies.**

Within groups of sex workers who would appear at first glance as being at an even risk of exposure to STD/HIV and therefore require standard BCC interventions, individual risk may vary considerably depending on degree of self-esteem, the weight of economic pressure, the level of education or the capacity to integrate into peer groups. **AIDSCAP could now induce a further phase of data analysis and target interventions more narrowly on sex workers whose behaviors and practices do not seem to have been influenced significantly by BCC. To this end, AIDSCAP should analyze the determinants of this resistance to change and develop approaches focused on this particularly vulnerable and critical sub-population.**

Clients in many subprojects were more often considered as a shadow population who could access information and education--and be motivated to use condoms--through sex workers. Few direct interventions on sex workers clients were shown to the Team apart from BCC projects aiming broadly at "sexually active young people and adults" or professional groups (truck drivers, factory workers, sailors) who were presumed to have occasional access to sex workers. **Further efforts should be developed by AIDSCAP to target clients at sites where sex work takes place.**

The shortage of STD drugs and condoms which hampered the initial start and the sustainability of several projects visited raises the issue of project implementation scheduling and of the logistic support extended by AIDSCAP's counterparts who are expected to supply these commodities. **In future agreements and subagreements, AIDSCAP should be able to purchase limited amounts of commodities (drugs, test kits, condoms) to ensure the timely and smooth start-up of its BCC activities. In these planning documents, it should also spell out preconditions to implementation that will assign responsibilities to all parties involved according to a set schedule.**

2. STD's

There are at least two types of actions that AIDSCAP could consider at a time when syndromic management strategies are introduced to new fields of operations and similar obstacles as those faced in Thailand and Brazil are likely to be encountered.

First, AIDSCAP could systematize a step-by-step approach in introducing the guidelines, ensuring that professional groups that are most likely to resist their application are involved early in the development of diagnosis and treatment norms. They should be presented with data (which AIDSCAP could gather) on the estimated incidence and prevalence of STDs in the population concerned, on the estimated access and utilization rates of STD services at different levels of sophistication and completeness and on the cost of expanding laboratory services to the extent desired by medical professionals.

Second, AIDSCAP could support or stimulate more operational studies to validate diagnosis and treatment guidelines which physicians are unlikely to accept on the sole premises that they have been found effective in a neighboring country or state. AIDSCAP should apply more caution to the phasing of its subprojects and review the assumptions listed in each subproject agreement. **AIDSCAP should schedule training or institutional strengthening activities with reinforced attention paid to preconditions that have to be met at each stage of project development, before moving on to the next.**

3. Condoms

Ongoing social marketing programs for condoms supported by AIDSCAP continue to be subsidized but projected sales, for example in Brazil and Ethiopia, are expected to progress towards financial self reliance of the schemes. **The Team found that, given the rising trends in condom demand and the increasing reluctance on the part of external donors to donate condoms, the social marketing approach was providing the highest guarantee of project sustainability. It recommends that AIDSCAP, through its subcontractors, should enhance its work in this area, give wider publicity to its achievements and document current and projected cost analyses of these initiatives.**

4. Behavioral Research

The Team noted that, although not participating in the decision of award of grants to their own project, several members of the Technical Working Group were also principal investigators or co-investigators of AIDSCAP funded research projects. **It is recommended that this practice be discontinued either by the withdrawal of grant applicants (principal and co-investigators) from the relevant TWG membership, or by the disqualification of TWG members to apply for AIDSCAP research grants.**

Research grants require a long gestation time which includes submission, several revisions as needed, field visits, peer review, finalization of proposal and development of a subagreement. **The complexity of generating quality thematic and commissioned research projects is such that AIDSCAP should limit its support to already approved projects and focus its work on time-limited projects with narrow objectives, rapid turn-around time and direct applicability of research findings to the improvement of program delivery.**

The goal of future research supported by AIDSCAP should be to generate information through research that is <u>essential</u> to the improvement of ongoing interventions and to the development of new ones that can be designed and tested in the short term. Thus, given the life span of AIDSCAP and the limited resources available to this program, research of a fundamental (academic) nature, based on complex study design and requiring years of data collection and analysis should receive the least priority in financial and human resource allocation.

The Team recommends that behavioral and social research supported by AIDSCAP be closely connected to ongoing projects and that a learning process be built within each project, as they develop, so as to feed back promptly into strategic design and lead to dissemination of experience gained--as empirically based as it may be-- and replication of projects, even before final study results are deemed of a sufficient scientific quality to qualify them for publication. Thus, given the life span of AIDSCAP and the limited resources available to this program, research of a more basic nature, based on complex study design and requiring years of data collection and analysis should receive the least priority in financial and human resource allocation.

5. Monitoring and Evaluation

The monitoring of the subprojects and country programs, and their process evaluation are constrained by several factors. First, there is in almost all projects a limited knowledge of the size of the target population and, as a result, rates (not absolute numbers) of access, coverage or use of services are impossible to derive or even estimate. Second, where estimates of populations to be reached are provided and rates calculated, insufficient or no account is taken of the renewal of the target population due to mobility and age structure dynamics. **A better definition of target populations, both in qualitative and quantitative terms is desirable. It should be updated periodically so as to focus activities specifically on new members of target populations who will require specific outreach efforts.**

The Team recommends that reinforced efforts be devoted to the refinement of evaluation indicators and processes. AIDSCAP should prepare itself better for the most likely situation where, at the end of its project life span, it may not be able to demonstrate the impact of its work on STD or HIV trends.

AIDSCAP should re-examine the objectives of its subprojects and define or re-define them specifically in research, demonstration or service terms. It should then spell out criteria of success and failure that reflect the specific objectives of each subproject and adapt monitoring and evaluation processes accordingly.

6. Policy Development

In collaboration with local USAID missions and International Agencies involved in HIV/AIDS and in socio-economic development, **AIDSCAP should develop and promote models of structural and institutional adjustments required to implement HIV/AIDS policies at the level of national priority it has been accorded.**

There is a pressing need for USAID to formulate a policy of integration of HIV/AIDS work with (not necessarily in) other programs. **The Team recommends that the pre-project appraisal carried out by AID before undertaking social and economic development programs should consider the potential positive or negative impact such programs may have on the spread of HIV. The potential impact that HIV/AIDS may have on social and economic development supported through USAID initiatives should also form part of this pre-project appraisal process.**

While it is especially relevant for AIDSCAP to work with corporations that have HIV-related discriminatory policies or practices, in order to help induce the needed changes, it should set its criteria for disassociating itself from projects that do not conform with international guidelines on HIV/AIDS prevention and are particularly resistant to change.

AIDSCAP should also ensure that national authorities, relevant international organizations (WHO in particular), local NGOs, and labor unions are made aware of policies and practices of mandatory pre-employment HIV testing and exclusion that may persist despite AIDSCAP's collaboration with corporate executives who have imposed such actions.

7. Relevancy and Comprehensiveness of AIDSCAP Programs

Although constrained by its scope of work and resource allocation, AIDSCAP is becoming more involved in HIV/AIDS care. The upcoming study on Voluntary Counseling and Testing is also a significant and valuable new area of involvement for AIDSCAP. **The Team recommends that, in each priority country, AIDSCAP should initiate or participate in needs assessment studies of strategic elements that are critical to effective prevention and care and publicize its findings among governmental, non-governmental and international groups in order to stimulate their response to the most acute needs that are outside the boundaries of AIDSCAP' scope of work. The "gaps" in coverage identified by these studies should form the basis for USAID coordination efforts within the international community. (See "International Coordination" under Management, below.)**

The comprehensiveness of AIDSCAP activities is generally in line with its scope of work but there are two areas where improvements will be needed in the short term: **(1) qualitative and quantitative evaluation should ascertain that every target population has access to and benefits from support generated under the three priority strategies, regardless of whether the source of such support is AIDSCAP or other group, and the extent to which this access is available and expected benefits are drawn; and (2) further efforts should be made to translate new knowledge into policy development at the local (state), national and international levels.**

In South-east Asia, AIDSCAP has expanded its activities to " Areas of Affinity" encompassing countries that have comparable levels and features of vulnerability to the spread of HIV, and where similar prevention approaches are relevant. **The Team recommends that the Area of Affinity approach be replicated and further supported by AIDSCAP, the USAID missions, regional offices and USAID/W.**

8. Sustainability

During the remainder of its current contract, AIDSCAP should plan methodically for a transfer of experience, expertise, as well as management and technical materials it has developed, to governmental and non-governmental groups participating in HIV/AIDS prevention and care programs.

9. Technical Support

The Team believes that AIDSCAP should now consolidate its work in priority countries and in associate countries where commitments have already been made. It should refrain from engaging in new country programs or projects. In order to facilitate the access by USAID missions to alternate sources of expertise, AIDSCAP should be prepared to recommend groups that can extend quality technical support to countries and facilitate their work by making available to them AIDSCAP guidelines and other technical materials.

Some flexibility should be applied to this recommendation. For example, AIDSCAP should still be prepared to extend its support to new subprojects in its present countries

of operation if such subprojects are essential to ensuring the comprehensiveness of ongoing work or if they are intended to generate, through evaluation and research, essential elements of knowledge that may be critical to the success of AIDSCAP supported activities in a particular country. However, in line with the reasoning behind the recommendation above, any requests for new project starts should be reviewed with great care.

10. Participation in "Global Learning"

The Team recommends that AIDSCAP should continue to disseminate widely the experience arising from its projects, including case studies and short narratives on empirically observed successes and failings encountered in the course of project implementation that will enhance the replication of successful approaches. More attention should be paid to the Intra-AIDSCAP dissemination of experience and lessons learned.

B. Operations and Management

1. Stage of Implementation

Sub-projects under the AIDSCAP Program are just now getting into the implementation stage or have been under implementation for too short a period to permit of evaluation. The reasons for this are discussed in the body of the report. However **no recommendations can be made at this point, based on sub-project evaluation, regarding the future of the AIDSCAP Program.**

The Team recommends that AIDSCAP sub-projects be the subject of another evaluation towards the end of FY 1995 and that any judgement on the future of AIDSCAP as a program to be managed by Family Health International await the results of that evaluation. (The Team notes specifically that this recommendation does not envisage a full re-evaluation of the Program at that time. Only the status and progress of sub-projects will need to be examined.)

Meanwhile, however, in the view of the Team, this Program does show enough promise so that existing sub-projects should be allowed to run their programmed course without the threat of undue disruption. **Accordingly, the Team recommends that the AIDSCAP Program be extended for one year beyond its currently projected termination date.** This will not only provide time for an in-depth look at future directions based on what is working and what isn't. It also will provide the time that will be necessary for full incorporation of USAID/Mission thinking into the program and, equally importantly, for the international coordination efforts that are required to allow AIDSCAP, or any successor program, to have the fullest possible impact within the framework of total donor efforts to combat AIDS.

2. USAID/Mission Input

Whether the AIDSCAP Program suffered *intellectually* from the lack of Mission input in its design must remain an open question. What is beyond question, however, is that the Program presently is suffering operationally from that lack.

It might also be noted that there is now a cadre of USAID field staff with a higher degree of relevant experience in HIV/AIDS than existed when the Program was designed.

The Team urges USAID to make a maximum effort now to reach out to its field Missions. This effort should have two objectives: 1) to accommodate, to the extent possible, conflicting views between USAID/W, the field Missions and AIDSCAP (headquarters and field!) as to what the present program ought to do, how it ought to be structured and, in general, how USAID's field programs and AIDSCAP should mesh; and 2) to fully incorporate Mission thinking into the next phase of USAID's HIV/AIDS program.

3. International Coordination

The "need for international coordination of development assistance efforts", for all that it is true, is a cliche. As a cliche it gets polite nods but seldom more attention than that unless someone pushes. USAID needs to push.

In the "normal" development assistance scenario failure of coordination among external donors results in less than optimal impact which, in turn, delays the changes sought. So, to state it simply, "development" takes longer than it need have. In the case of HIV/AIDS, however, we are faced with a threat of "development" going backwards. That is to say, failure by the international donor community to optimize the impact of whatever resources can be brought to bear on this problem runs a high risk of accelerating the undoing of much of what international development assistance has managed to accomplish over the past 40 years.

The possibility also exists (see the recommendation below on this point) that what is involved here is not only "negative" economic development in a series of LDC's but also a negative impact on the growth of industrialized countries through higher prices for imported raw materials and lessened demand for exports.

Efforts at international coordination are going on on a number of operational levels. They are not as effective as they need to be however, as judged by the "gaps" found by the Team in the externally-supported programs of the countries visited.

What is needed to support and flesh out the operational-level coordination efforts presently underway is agreement and continuing oversight from the highest bureaucratic levels of the international donor community, i.e. **the heads of international development assistance agencies.** The organization set up to accomplish that result is the Development Assistance Committee of the OECD.

The Team recommends that USAID explore the feasibility of a(nother ?) DAC meeting on HIV/AIDS. The purpose of such a meeting should be to attain the greatest degree of consensus possible on 1.) resource needs and commitments to provide those resources and 2.) roles and missions, i.e., who will do what. An objective of such a meeting should be to eliminate programmatic "gaps" with respect to such items as condoms, STD drugs, testing kits, care and other goods and services identified elsewhere in this report as vital but difficult or impossible to come by in some countries.

(This is not to suggest that the DAC become a "coordinating mechanism" on AIDS in an operational sense. That function is better played by organizations specifically set up to accomplish that purpose, such as the Global Management Committee (GMC) of the WHO Global Program on AIDS or the newly created UN AIDS program. What is suggested is that the DAC probably is the best agency available for the highest possible level of attention to the problem.)

Whatever arrangements for international coordination are pursued, whether through the DAC or through bi-lateral contacts with his counterparts, **A/USAID will have to become involved.**

4. Decentralization

The desire on the part of USAID and FHI for tight, centralized control of a large project just getting off the ground is understandable in a project of this size and scope. However, the Program has been running for several years now, precedents and operating procedures are established and there is a well-trained, qualified and highly motivated staff on the ground. Continued centralized administration now is a hinderance to efficient attainment of Program objectives.

The Team feels strongly that, in order to speed up program implementation and improve flexibility (under central policy, but not case-by-case operational, guidance) AIDSCAP needs to shift to a decentralized operation. Some suggestions in the Finance area are set out below. Certainly sub-project approval should be delegated at least to the Regional Office level. Other candidates for delegation (the list is not exclusive) would be: provision of short-term technical assistance to USAID Missions; approval of research proposals developed and "peer-reviewed" in the field; consideration of new proposals from sub-contractors/subgrantees; approval of (sub-)contractor's monitoring and evaluation plan, and the use of consultants from the contractor's roster.

The above examples are taken directly from FHI's contract. There undoubtedly are other areas in which increased delegation/decentralization can be implemented.

Carrying out this recommendation will require changes to the contracts under which this program operates. In a few cases, particularly in the Finance area, it will require personnel shifts from Washington to Regional Offices. Most of all, however, it will require a focus in Washington - by both USAID and AIDSCAP - on **policy**. In exchange for strong, almost day-to-day operational guidance, strong long-term policy guidance will have to be communicated to the field. And then field offices need to be left to do the job.

5. Economic Impact Studies

AIDSCAP currently is carrying out a series of economic impact studies designed to convince policy-makers in cooperating countries of the nature of the problem presented by HIV/AIDS with respect to economic development in their countries. Those seen by the Team are well done for their purpose, indeed, amazingly well done given the constraints of time and data availability under which the researchers work. However, they are necessarily (given the limitations mentioned in the previous sentence) "quick and dirty" studies.

The Team believes there may be something more profound going on here than the present series of studies can (or is designed to) bring out. That is that AIDS in the "Third World" may constitute a measurable threat to economic growth in the "industrialized world." At least two dimensions of this equation are obvious: 1.) higher prices for imported raw materials as labor costs in producing countries rise due to scarcity of labor, and 2.) diminishing export markets both directly, in terms of numbers of deaths, and indirectly as costs associated with the epidemic sap national budgets and lower incomes in affected LDC's. There may be other effects.

The Team recommends that USAID and AIDSCAP carry out a series of economic studies in some 4 to 8 key developing countries (Brazil, Thailand, South Africa and India seem

likely candidates) designed to determine likely impact of AIDS projections as we now have them on both export prices for selected key raw materials and import potential for the chief exports of the industrialized countries. The objective should be to start, now, to measure the potential impact of the AIDS epidemic in "LDC's" on the industrialized world.

Not to belabor the point, but should USAID be able to get the DAC involved in carrying out these studies (perhaps on a continuing basis as more data becomes available?) a ready path would be smoothed towards attaining a greater degree of international consensus on the potential impact of the AIDS epidemic and the need for the industrialized countries to move effectively to confront it.

6. Reporting Requirements

The Team recommends that USAID and AIDSCAP review the reports now being required to be submitted by the field and eliminate - or reduce the periodicity - of those that are not now reviewed and used on a continual basis. As part of the effort to reduce reporting requirements, AIDSCAP field offices and USAID Missions may be asked to "store" information in a quickly-retrievable form so that the data can be made available to Washington on an urgent basis if needed.

7. Ongoing Operations

Field operations were severely disrupted by the switch from a cooperative agreement mode of operations to a contract mode. Those operations now need to be allowed to proceed in a "normal" manner to see what they can produce. (As stated elsewhere in this report, the Team thinks the prognosis is hopeful, overall.)

Accordingly, **the Team urges that operational changes recommended in this report be carried out so as to avoid, to the greatest extent possible, further disruption of sub-projects under this program.**

8. Sustainability; Resource Needs

The scope of work for this study asks the Team to "prescribe which additional resources USAID should consider committing in the area of HIV/AIDS prevention and control to ensure the long run sustainability of developing countries' prevention and control capacity."

The Team finds that question unanswerable as asked. That more is needed, on an overall basis, is unarguable. Hence the insistence here on renewed and increased emphasis on international cooperation among the donor community. That having been said however, and without any basis for estimating "how much is enough" still it seems fairly clear to the Team that neither USAID on its own nor the international donor community as a whole is likely to come up with the resources needed to do anything more than slow the epidemic in some countries. The prognosis here is not hopeful.

A number of recommendations are made in this report on the issue of sustainability and how to move towards it. Those suggestions are based on the recognition that the vast bulk of the resources required to control and/or prevent AIDS will have to come from the budgets of the countries affected. Some of those countries - Brazil and Thailand come to mind - probably can mobilize significant resources. Others, such as Senegal and Kenya cannot and, indeed, the increasing economic impact of AIDS may increasingly diminish their capacity to do so.

Under these circumstances, it seems to the Team that the question for USAID is not so much "How Much?" but, simply, "How?" That is, given the fact that no realistic estimate of how much USAID is liable to be able to devote to this problem will be adequate, the question is how to invest those resources available so as to make the maximum impact. The recommendations in this report are designed to help USAID answer that question.

C. Finance

1. Financial Management

Although AIDSCAP has developed information gathering instruments, and has worked with its field offices in the financial management area, a significant amount of strengthening remains to be done in the field in order for AIDSCAP to truly make a significant contribution in institution building at the IA level.

The Team recommends that Financial Management be viewed as a support function to the technical areas of AIDSCAP and, most importantly, to AIDSCAP's Implementing Agencies.

AIDSCAP should re-examine the skills of Headquarters and field finance staffs and re-assign those who have demonstrated field performance or implementation skills, as opposed to just technical expertise, to the task of delivering technical assistance to subordinate levels of the organization and to IA's.

More systematic communication between regions should also be encouraged by Finance/Headquarters by developing a mechanism that ensures exchange of ideas and experiences between the finance staffs in the field.

The systems developed by the Finance Offices in Brazil and Jamaica should be examined by their fellow finance staffs in other regions and in AIDSCAP/W for recommendations and possible implementation as AIDSCAP-wide systems. The review of these systems should also include the possibility of looking into off-the-shelf fund accounting systems.

2. Accounting

a. The Accounting System

If AIDSCAP as a project is to continue beyond 1996, the Team recommends that FHI consider implementing an accrual basis fund accounting system in its AIDSCAP project field offices. There are various off-the-shelf computerized packages that have been implemented by various NGOs both in the US and abroad.

Before looking into these packages, AIDSCAP should consider looking into two systems developed by field staff. Both the Finance Directors in Brazil and Jamaica have been working on accounting systems for their own offices, though, at this point these systems are still in the development stage. The Brazil system is computerized and it is the most advanced in its development stage. The Jamaica system is still manual form.

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1) Field Expenditure Tracking System

An "expenditure tracking system" was developed by AIDSCAP/Headquarters for use by its field offices both at the regional and country levels. This bookkeeping system might not be the most appropriate for monitoring, controlling and recording the transactions of a multi-million dollar project such as AIDSCAP.

2) Internal Accounting Control

AIDSCAP should look into the problem of staffing in the Finance departments in the field. Finance is a very important function that requires staff to be able to carry out its duties and be accountable for the funding provided by the donor to the project.

It is recommended that AIDSCAP conduct an inventory of its finance department staff so that at least two staff members are placed in each of these departments. It is understood that staffing should be based on need, and the needs in this area are very serious.

b. Accountant's Handbook for AIDSCAP Project

1) Revision of Handbook

It is recommended that the Handbook be reviewed and updated by AIDSCAP/-Headquarters with the input of both Regional and Country offices. It is also recommended that the Handbook include the necessary instructions on how to calculate and incorporate the inflation factor in budgeting and reporting.

c. Fixed Assets

Several IA's implementing AIDSCAP activities as well as both RO's and CO's have purchased and/or will be purchasing equipment.

It is recommended that the Fixed Asset Register (Schedule of Project Inventory) be revised to include: (1) the asset Identification Number; the Position Number of the asset, for example: 001 Central Building, 002 Finance Department, 010 Accounting Office, etc., the Category, e.g.: 01 Office Equipment; 02 Lab Equipment, etc., Installation Date; Supplier; Brand; Model; Serial Number; Payment Date; check; Condition in which the item was received; and Original Cost. Depreciation: Method Used (Straight Line suggested); Useful Life; Remaining Useful Life; and Rescue Value.

d. Budgeting

Significant budgeting modifications should be implemented at AIDSCAP. In many instance both at HQ and in the field there is a tendency to over-budget and in fewer instances under-budget resulting in differences between "planned and actual expenditures" sometimes of over 50% such as the case of the "Behavioral Research Budget". In some instances these differences have been due to a slow start-up of the project or to sharp differences in the projected and actual exchange rate but in other cases the budgeting procedures themselves are a fault.

The development of a budget methodology that expresses the real requirements of AIDSCAP's program areas is still to be implemented.

AIDSCAP should take measures to increase budgeting efficiency, i.e. provide for allocation decisions made on the basis of need and resources availability. This should be tracked in future evaluations of the program. Indicators of achievement should include budget allocations to projects or activities based on realistic projected needs.

AIDSCAP should re-examine all of its budgets in light of program/technical projections and re-program funds accordingly.

RA's should be advised again that when IA's exceed their budgeted amounts as agreed to with AIDSCAP, the RA should not approve further reimbursement.

e. External Audits

If AIDSCAP's audited accounts exercises must be managed by FHI headquarters in North Carolina, then it is recommended that the responsibility for follow-up on implementation of recommendations and observations made by external auditors be placed with AIDSCAP/Headquarters Finance Department in Arlington.

FHI can still keep control of external auditing in its headquarters in North Carolina but the follow-up must be done at the project level for project Implementing Agencies. Documentation pertaining to both the audit exercises — the audited accounts reports and follow-up documentation — should reside at the project's Arlington headquarters for project Implementing Agencies.

AIDSCAP/Arlington should be charged with the responsibility of communicating with the Regional and Country offices until the implementation of the external auditors recommendations and correction of weaknesses identified by the audits takes place.

AIDSCAP/Arlington should present a summary monthly report to FHI/North Carolina informing Headquarters on the status of implementation and follow-up.

f. Centralization/Decentralization

The Team recommends that AIDSCAP move quickly towards decentralizing the finance function.

This need not imply losing control of the project's finances.

Regional and Country Offices are audited by an external auditing firm on an annual basis. Reimbursements according to the Handbook are speeded up by the receipt of two documents: Expenditure Summary Report and the Journal Entry Form. AIDSCAP could also request, in addition to the above two documents: (a) a Cash Flow Projection for the following month, (b) Cash on Hand and (c) a Variance Analysis between Planned and Actual for the past month, all in one form.

This documentation could be analyzed and disbursements made based on the results of this analysis. The present system of reimbursement based on past month's expenditures should be discontinued.

The rest of the documentation as well as copies of vouchers should be dropped. This type of control can be exercised through monitoring of the IA's by the CO's; the CO's by the RO's; and the RO's by AIDSCAP/Headquarters.

The verification of expenditures and accuracy of their reporting would be confirmed by the CO's in the case of the IA's, by the RO in the case of the CO's, and by AIDSCAP/Headquarters in the case of the RO's. The annual External Audit would make the final verification and would issue an opinion.

3. Project Financial Management

a. Reports and Financial Analysis

There is a difference in the kind of information required by the different parties involved in managing and monitoring AIDSCAP's finances. USAID's requirement for information varies from the information required by the project's management; the latter demands a greater level of detail on both the income and expenditure side.

FHI operates an accounting system that segregates income and expenditure by source. The FCO component of the system should be able to segregate this information and as a matter of fact it does so to a certain degree. **What AIDSCAP should do is to review the FCO system to ensure that a breakdown of income and expenditure by source of funding, by technical area, and by administration is incorporated into the system.**

b. Cash Management

1) Advances to Implementing Agencies and Field Offices

AIDSCAP should take immediate action to reduce the $1,154,000 and US$2,117,000 it has in cash advances to IA's and RO's/CO's to a third of those amounts.

(See also the recommendation for reimbursement based on cash on hand and cash flow projection under "decentralization of finance" above.)

2) Interest-Bearing Bank Accounts

The Team found that this practice is being observed throughout AIDSCAP offices worldwide not just in Brazil. The Team agrees with this practice in countries with spiraling inflation, devaluations, and continuous shifts in the economy and reiterates USAID/Brazil's recommendation that:

a) The AID Project Officer periodically review these procedures as part of her/his normal project monitoring responsibilities.

b) A formal review of the continuing need for this practice should be conducted by the external audit during the annual auditing exercise to certify that the interest earned by AIDSCAP is being used as mandated by USAID's regulations, and to recommend either the continuance or discontinuance of this practice according to the country's economic circumstances.

   At present AIDSCAP's auditors, Ernst & Young, are incorporating into their auditing Terms of Reference the examination of these accounts and the final destination of the interest earned in these accounts. So far, there have been several cases in which the funds have not been appropriately credited to the AIDSCAP account.

(c) It is also recommended that AIDSCAP document the authorization and/or waiver obtained from AID to authorize the Implementing Agencies to keep US$100 a year from the interest earned on interest-bearing accounts.

4. Financial Management Support

A technical assistance plan to include further training should be developed and implemented by AIDSCAP/Headquarters. This plan should focus on strengthening and fine-tuning AIDSCAP's field finance departments' staff's skills and decision-making capacity. The training should include the development of a strategic plan that ties into the organization's general plan and objectives.

Mechanisms for communication among regions and within regions should be developed, and communication should be encouraged.

The finance department's objectives should be quantified and clearly tied to AIDSCAP's mission. They should be formulated by the field offices' management teams. These objectives should be related to the project's *mission*, and they should be *measurable* to allow the finance function to continually assess its performance.

At the most general level, AIDSCAP's financial departments have to develop a clear sense of purpose and goals, in other words, define *their mission*. One typically thinks of organization-wide mission statements, but a technical department such as finance also needs its own, localized version. Once the departmental mission has been defined, the mission can be translated into measurable objectives which allow the financial function to continually monitor its performance. All finance staff should be familiar with, and preferably participate in, the development of their department's strategic plan.

Performance criteria should be developed to evaluate the finance function, particularly performance criteria which are meaningful internally, such as the interaction with other functions, staff capabilities, the effectiveness of established internal controls, and the results of the investment strategies.

a. Training and Technical Assistance

The Team recommends that Resident Advisors and Country and Regional Office Directors attend short courses on the basics of financial management. This course curriculum should consider but should not be limited to: Cash flow management; budgeting; financial reporting; audited accounts' balance sheet interpretation and observations. It is important for these Managers to know what they can get from their accountants and their systems. It is also important for them to know what observations in audited accounts statements mean and how to follow-up on them.

In addition, a plan of action should be prepared by finance where TA activities are planned in conjunction and with the feedback of the regional offices.

Trips of one and two weeks to Africa should be avoided because of the high costs involved. The Team does not consider one or two weeks sufficient time to provide TA in the field. The Headquarters office should include in their plans periodic visits to Country programs and their implementing agencies as part of Headquarters monitoring.

5. Capacity Building and Sustainability

a. Sustainability/Strengthening of AIDSCAP'S IA's

Sustainability and institutional strengthening can be provided in several ways including:

1) Training in proposal development and tapping other financial resources.

2) Assistance to IA's in tracking recurrent costs for projects to identify major recurrent costs problems, identify the full costs of their operation, and assess future financial requirements when AIDSCAP is no longer able to.

3) Conduct cost benefit analyses to convince policy makers of the benefits of investing in AIDS prevention

4) Cost effectiveness studies of the interventions to evaluate the relative cost-effectiveness of the various interventions.

5) Cost recovery within the AIDSCAP program may offer opportunities worth considering. The most feasible possibilities for recovering some of the costs of the program may come through the sale of condoms and private sector initiatives. This does not preclude the possibility of some of AIDSCAP projects recovering a portion of their costs through fees-for-services.

   Pilot tests should be conducted for a short period of time (e.g. three months) at those activities/projects were there is a possibility for recovering costs. These pilot tests should collect the necessary data to determine the socio-economic status of the group of clients under study.

   The pilot tests should result in the development of a final uniform and standardized socio-economic data collection instrument to be used by those facilities selected or identified as having potential for cost recovery. This instrument should be fine tuned with assistance and feedback from the field.

b. Private Sector Leveraging

AIDSCAP should continue to encourage this type of initiative. In terms of sustainability these are activities that perhaps have the biggest potential to become sustainable in the short to medium term.

c. Cost Sharing (Counterpart Funding)

The Team feels, however, that due to the difficulties encountered by the Regional Offices and the IA's in obtaining this information, AID should reconsider the need for this request to only two countries in the project.

Another important consideration would be the cost incurred by CO's to obtain this information since in the majority of cases this information is not automatically forthcoming particularly from host government agencies. An added cost in obtaining this information would be through verification. It is rather difficult for a project to verify costs incurred at the host government level since government books of account are not available to private organizations for monitoring.

6. Conversion from Cooperative Agreement to Contract

This is the first time a cooperative agreement was converted to a contract in the middle of the project. It created delays and additional costs.

It is the Team's understanding that AIDSCAP Headquarters and the USAID reached agreement some time ago to modify the Q Contract to incorporate a lower multiplier. However, the modification still has not been issued. Because the Contract is not modified there is ambiguity at all levels within AIDSCAP as to how to prepare budgets and invoices.

It is recommended that USAID immediately issue the modification to change the multiplier.

7. Timeliness of AID/Washington Reviews

The Contracts require a number of reviews and approvals by AIDSCAP/W and the COTR and/or the Contracting Officer. So that the AIDSCAP Project not incur further mini-delays, **it is recommended that those reviews and approvals be done in a timely manner. A maximum of one week each is recommended for required action by AIDSCAP/W,the COTR and/or the Contracting Officer.**

It is also recommended that USAID immediately prepare all outstanding modifications (ex: the lower multiplier on the Q Contract) and that all future modifications be prepared expeditiously in order not to impede program implementation.

8. Subagreement Pre-award Financial Review and Assessment Procedures

Instructions were sent to RO's and CO's regarding Subagreement Pre-Award Assessments. Unfortunately because these instructions have no date, and the Regional Office that handed these instructions to us just had them attached to the Accountant's Handbook, the Team cannot state at this point that these instructions form an integral part of the Handbook's general information. Nevertheless, the instructions state that "an assessment is necessary for any potential subagreement of more than $25,000 annually. At the discretion of the AIDSCAP Regional Finance Officer, an assessment may be requested for projects of $25,000 or less".

It appears that this contractual requirement was not clearly understood by AIDSCAP/Headquarters. Consequently, the wrong instructions were passed on to the field. The $25,000 threshold applies to the auditing of Implementing Agencies, that is, those organizations which receive US$25,000/year or more in US Government funds (either directly or indirectly) are to be audited by an external auditing firm on a yearly basis. The Pre-Award Assessment, however, is to be carried out by AIDSCAP Regional/Country office regardless of the amount of the award or grant to an Implementing Agency.

It is recommended that AIDSCAP Headquarters immediately issue corrected instructions to the Regional and Country Offices.

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